

DISTRICT OF COLUMBIA OFFICIAL CODE

2001 Edition

TITLE 31

**Insurance and Securities
(Chapters 10 to End)**



40th ANNIVERSARY
of
HOME RULE

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DISTRICT OF COLUMBIA

OFFICIAL CODE

2001 EDITION

Containing the Laws, general and permanent in their nature,
relating to or in force in the District of Columbia (Except such
laws as are of application in the General and Permanent
Laws of the United States) as of September 13, 2012.

VOLUME 16

Title 31

Insurance and Securities
Chapters 10 to End



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DISTRICT OF COLUMBIA
OFFICIAL CODE

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Foreword to 2013 Commemorative Set

LexisNexis presents the 2013 republication of the District of Columbia Official Code, 2001 Edition to the D.C. bench and bar and to the citizens of the District of Columbia in a sincere belief that it will prove a material contribution to the orderly and efficient conduct of the government of the District and to the practice of law. LexisNexis is proud to help commemorate the 40th anniversary of Home Rule for the District of Columbia.

LexisNexis continues its tradition of excellence with its District of Columbia Official Code, 2001 Edition. This 2013 Volume 16 replaces any existing Volume 16 of the 2001 Edition and its 2012 Supplement, both of which may now be discarded, recycled, or retained for historical reference. Future supplements will be keyed to this 2013 Volume and not to any of its predecessors.

The District of Columbia Official Code, 2001 Edition, represents the eighth compilation of the laws of the District of Columbia and reflects an extensive renumbering of the 1981 Edition. Users should consult the historical citations at the end of each statute, and corresponding amendment notes, as guides to legislative currency. Research features such as case annotations, section references, effect of legislation notes, editor's notes, and the comprehensive index have been prepared by LexisNexis. Your set is kept up to date through regular supplementation, free access to the on-line Official Code at <http://www.lexisnexis.com/hottopics/dccode> and the periodic replacement of volumes. All case citations are Shepardized for accuracy and continued relevance. LexisNexis also publishes a District of Columbia Advance Legislative Service (ALS). The ALS gives you the latest session laws as they are passed, along with tables showing you which sections of the Code are affected.

We actively solicit your comments and suggestions. If you have questions or comments about the statutes, or if you have suggestions regarding index improvements, please write to us or call us toll-free at 1-800-833-9844; fax us toll free at 1-800-643-1280; E-mail us at customersupport@bender.com; or visit our website at <http://www.lexisnexis.com>. By providing us with your informed comments, you will be assured of having a working tool which increases in value each year.

LEXISNEXIS

June 2013

PREFACE TO THE 2001 EDITION

The 2001 Edition of the District of Columbia Official Code marks the eighth time that a compilation of the laws of the District of Columbia has been published by, or under the authority of, the government of the District of Columbia or that of the United States. The District of Columbia Code was first published in 1929; eleven years later, the Second Edition (1940) was published; another eleven years later, the Third Edition (1951); ten years later, the Fourth Edition (1961); six years later, the Fifth Edition (1967); another six years later, the Sixth Edition (1973); and 8 years later, the Seventh Edition (1981) was published. The time between the publication of the Seventh Edition and this Eighth Edition represents the longest period, by almost a decade, that the District of Columbia Code has gone unrevised in its 72 year history.

The District's Charter, which in 1973, established the current tripartite government of the District of Columbia, makes it incumbent upon the legislative branch to publish and codify every act of the Council, as the Council directs, upon becoming law, so that the residents of the District may have ready access to the laws by which they are governed. In 1973, however, the framers of the District's constitution could not have foreseen the incredible technological advances that would occur in the next 25 years nor the impact they have on the Code.

With the close of the 20th Century the world has witnessed the triumph of the Information Age, the rise of the World Wide Web, and the explosion of word processing and data storage technology. These phenomena have helped make the reproduction of legal text and data a fast, easy, and inexpensive enterprise, giving rise to a plethora of publishing mediums, and have made it a relatively simple task to reproduce existing legal text, including the District of Columbia Code. The rapid rise of the Computer Age has allowed virtually anyone with an ordinary personal computer to reproduce and compile the laws of the District of Columbia.

The laws of the District, however, are fluid, not stagnant, as they are amended several times each year. The quality and accuracy of publications not directed by the Council are beyond its control. The Council can only warrant the Code for which it has authorized publication. Therefore, in order to ensure that the residents of the District may distinguish between the compilation of District laws as produced under the direction of the elected officials of the District of Columbia and those of other persons, we have added the word "Official" to the title of the Code. Also to ensure that the Council never loses the right to publish its own laws, the government of the District of Columbia has retained the copyright to the District of Columbia Official Code.

The codified laws of the District of Columbia are created as a result of legislative action on the part of 13 individuals elected by the residents of the

District of Columbia to enact the laws that govern the District, and by the Congress. Once the legislative process is complete, the Council, through its delegation of authority to its Office of the General Counsel, codifies the laws in the form of this Code. In the process of codification, the Office of the General Counsel interprets any discrepancies in the drafting of the laws using commonly recognized rules of statutory construction. No other entity is authorized by law to make these determinations. As set forth by federal law and recognized by the Courts of the District of Columbia, this Code establishes *prima facie* evidence of the laws in force in the District of Columbia.¹ It is this continuity of authority, from enactment to codification to judicial review that gives this Code its authenticity and officiality as the content of the laws of the District of Columbia.

The 2001 Edition represents a recodification of the 1981 Edition in that it contains a reorganization of the presentation of the laws, inclusion of some previously omitted legal provisions, and the omission of non-substantive extraneous provisions. The theory behind the recodification is to purify the organization of the Code which over many decades has seen the haphazard mixing of original (“organic”) provisions of laws throughout the Code. In the 2001 Edition, we have established a system of codification that follows the legislative drafting principals established over many years in the Council’s Office of the General Counsel.

The recodification is not an overhaul of the Code. Although a cleanup of the antiquated, repealed and omitted provisions is long overdue, it is not the province of the Office of the General Counsel to determine which laws should be expunged as obsolete. Such decisions should be left to a working group commissioned by the Council to recommend revisions to the Code. The Office of the General Counsel has simply separated the organic laws into discrete divisions and topical categories. As much as is possible, we have followed a rule that requires that all organic law remain intact: closely following the layout of the originating act. We have retained notes to repealed sections to aid in legal research and preserved the numbering style that was first introduced in the Second Edition. Thanks to the resourcefulness of the publisher and the Council’s Office of the General Counsel staff, we have corrected provisions of law erroneously added to, or deleted from, prior editions.

The Code is organized into eight Divisions of practical law: government organization; judicial organization; decedent estates; criminal law; business law; education; property; and general laws. Each division is subdivided by subject matter called **Titles**, organic laws, called **Chapters** and **Subchapters**, and finally, individual **Sections** representing the individual sections of organic law. Occasionally, **Subtitles** are used to organize chapters of organic law, **Units** to organize subchapters, and **Parts** and **Subparts** to organize the additional divisions within the organic law. One important change that the user will notice, and hopefully appreciate, is that the District’s Charter, the Home Rule Act, is codified in its entirety in one location so that the

1. See 1 U.S.C. § 204(b) (1994); *Sheetz v. District of Columbia*, 629 A.2d 515, 519 (D.C. 1993).

framework of the current District government can be readily found. We hope that the organization of the 2001 Edition of the District of Columbia Official Code will serve as a foundation for further refinement by future law revision commissions or their equivalent.

The 2001 Edition has been prepared under the supervision of Benjamin. F. Bryant, Jr., Codification Counsel, Office of the General Counsel, Council of the District of Columbia.

_____/s/_____

Linda W. Cropp

Chairman

Council of the District of Columbia

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Charlotte Brookins-Hudson

General Counsel

Council of the District of Columbia

USER'S GUIDE

In order to assist both the legal profession and the layman in obtaining the maximum benefit from the District of Columbia Official Code, a User's Guide has been included in Volume 1 of the Code. This guide contains comments and information on the many features found within the District of Columbia Official Code intended to increase the usefulness of the Code to the user.

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*Title has been enacted as law.

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*Title has been enacted as law.

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§ 31-1001. Report requirement.

(a) Every insurer domiciled in the District of Columbia shall file a report with the Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner") disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless such acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements that have been submitted to the Commissioner for review, approval, or information purposes pursuant to other provisions of the insurance code, laws, regulations, or other requirements.

(b) The report required in subsection (a) of this section is due within 15 days after the end of the calendar month in which any of the transactions enumerated in subsection (a) of this section occur.

(c) One complete copy of the report, including any exhibits or other attachments, shall be filed with:

- (1) The insurance department of the insurer's state of domicile; and
- (2) The National Association of Insurance Commissioners.

(d) Repealed.

(May 24, 1996, D.C. Law 11-123, § 2, 43 DCR 1542; Mar. 24, 1998, D.C. Law 12-81, § 42(a), 45 DCR 745; Oct. 21, 2000, D.C. Law 13-191, § 6(a), 47 DCR 7311; Apr. 13, 2005, D.C. Law 15-354, § 42, 52 DCR 2638.)

Section references. — This section is referred to in §§ 31-1002 and 31-1003.

Prior Codifications. — 1981 Ed., § 35-4101.

Effect of amendments. — D.C. Law 13-191 repealed subsec. (d) providing:

"(d) All reports obtained by or disclosed to the Commissioner pursuant to this chapter shall be given confidential treatment and shall not be subject to subpoena, shall not be subject to disclosure under subchapter II of Chapter 15 of Title 1 1981 Ed., and shall not be made public by the Commissioner, the National Association of Insurance Commissioners, or any other person except to insurance departments of other states, without the prior written consent of the insurer to which it pertains, unless the Commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the Commissioner may publish all or any part in the manner the Commissioner may deem appropriate."

D.C. Law 15-354, in subsec. (a), substituted

"of the Department of Insurance, Securities, and Banking" for "of Insurance and Securities".

Legislative history of Law 11-123. — Law 11-123, the "Insurance Industry Material Transactions Disclosure Act of 1996," was introduced in Council and Assigned Bill No. 11-239, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on February 6, 1996, and March 5, 1996, respectively. Signed by the mayor on March 15, 1996, it was assigned Act No. 11-230 and transmitted to both Houses of Congress for its review. D.C. Law 11-123 became effective on May 24, 1996.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 13-191. — Law 13-191, the "Insurer Confidentiality and Infor-

mation Sharing Amendment Act of 2000," was introduced in Council and assigned Bill No. 13-706, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was

assigned Act No. 13-419 and transmitted to both Houses of Congress for its review. D.C. Law 13-191 became effective on October 21, 2000.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

§ 31-1002. Acquisition and disposition of assets.

(a) No acquisition or disposition of assets need be reported pursuant to § 31-1001 if the acquisitions or dispositions are not material. For purposes of this chapter, a material acquisition (or the aggregate of any series of related acquisitions during any 30-day period) or disposition (or the aggregate of any series of related dispositions during any 30-day period) is one that is nonrecurring and not in the ordinary course of business and involves more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(b)(1) Asset acquisitions subject to this chapter include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(2) Asset dispositions subject to this chapter include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction, or other disposition.

(c) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

- (1) Date of the transaction;
- (2) Manner of acquisition or disposition;
- (3) Description of the assets involved;
- (4) Nature and amount of the consideration given or received;
- (5) Purpose of, or reason for, the transaction;
- (6) Manner by which the amount of consideration was determined;
- (7) Gain or loss recognized or realized as a result of the transaction; and
- (8) Names of the persons from whom the assets were acquired or to whom they were disposed.

(d) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if:

(1) The insurer has less than \$1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement; and

(2) The net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

(May 24, 1996, D.C. Law 11-123, § 3, 43 DCR 1542.)

Prior Codifications. — 1981 Ed., § 35-4102. legislative history of D.C. Law 11-123, see Historical and Statutory Notes following § 31-1001.

Legislative history of Law 11-123. — For

§ 31-1003. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

(a) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported pursuant to § 31-1001 if the nonrenewals, cancellations, or revisions are not material.

(b) For purposes of this chapter, a material nonrenewal, cancellation, or revision is one that affects:

(1) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(A) More than 50% of the insurer's total ceded written premium; or

(B) More than 50% of the insurer's total ceded indemnity and loss adjustment reserves.

(2) As respects life, annuity, and accident and health business, more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(c) As respects either property and casualty or life, annuity, and accident and health business, either of the following events shall constitute a material revision which must be reported:

(1) An authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(2) Previously established collateral requirements that have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(d) No filing shall be required if:

(1) As respects property and casualty business, including accident and health business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business; or

(2) As respects life, annuity, and accident and health business, the total reserve credit taken for business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement prior to any cession.

(e) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) Effective date of the nonrenewal, cancellation, or revision;

(2) The description of the transaction with an identification of the initiator thereof;

(3) Purpose of, or reason for, the transaction; and

(4) if applicable, the identity of the replacement reinsurers.

(f) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis

unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than \$1,000,000 total direct plus assumed written premiums during a calendar year that \$1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

(May 24, 1996, D.C. Law 11-123, § 4, 43 DCR 1542; Mar. 24, 1998, D.C. Law 12-81, § 42(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4103.

Legislative history of Law 11-123. — For legislative history of D.C. Law 11-123, see Historical and Statutory Notes following § 31-1001.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-1001.

§ 31-1004. Confidentiality.

(a) All reports obtained by or disclosed to the Commissioner under this chapter in the possession or control of the Department of Insurance, Securities, and Banking shall be confidential and privileged; shall not be subject to subchapter II of Chapter 5 of Title 2; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in a private civil action without the prior written consent of the insurer to which it pertains; provided, that the Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(b) If the Commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by publication of the information subject to subsection (a) of this section, the Commissioner may publish all or any part in the manner that the Commissioner considers appropriate.

(c) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not be permitted or required to testify in a private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(d) To assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners, including its affiliates and subsidiaries; and with state, federal, and

international law enforcement authorities; provided, that the recipient agrees, and has the legal authority, to maintain the confidentiality and privileged status of the documents, materials, or other information;

(2) May receive documents, materials, or other information, including confidential and privileged documents, materials, or other information, from the National Association of Insurance Commissioners, including its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; or

(3) May enter into agreements governing the sharing and use of information consistent with this section.

(e) No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this section or of sharing as authorized in subsection (d) of this section. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(May 24, 1996, D.C. Law 11-123, § 4a, as added Oct. 21, 2000, D.C. Law 13-191, § 6(b), 47 DCR 7311; June 11, 2004, D.C. Law 15-166, § 4(f), 51 DCR 2817.)

Effect of amendments. — D.C. Law 15-166, in subsec. (a), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(f) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 13-191. — For Law 13-191, see notes following § 31-1001.

Legislative history of Law 15-166. — Law 15-166, the “Consolidation of Financial Services Amendment Act of 2004”, was introduced in Council and assigned Bill No. 15-518, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 6, 2004, and February 3, 2004, respectively. Signed by the Mayor on February 27, 2004, it was assigned Act No. 15-385 and transmitted to both Houses of Congress for its review. D.C. Law 15-166 became effective on June 11, 2004.

CHAPTER 11. INSURANCE PREMIUM FINANCE COMPANIES.

Sec.

- 31-1101. Applicability of provisions.
 31-1102. Definitions.
 31-1103. Licenses — Persons required to obtain; fees; other requirements.
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Sec.

- 31-1106. Records.
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 31-1109. Service charges.
 31-1110. Delinquency charges.
 31-1111. Cancellation of insurance contracts.
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§ 31-1101. Applicability of provisions.

The provisions of this chapter shall not apply with respect to:

- (1) Any insurance company licensed to do business in the District;
- (2) Any banking institution, trust, loan, mortgage, safe deposit, or title company, building association, credit union, moneylenders, or common trust fund authorized to do business in the District;
- (3) The inclusion of a charge for insurance in connection with an installment sale of a motor vehicle made in accordance with Chapter 6 of Title 50; or
- (4) The financing of insurance premiums in the District in accordance with the provisions of §§ 28-3301 and 28-3302 relating to rates of interest.

(Oct. 9, 1940, ch. 792, ch. III, § 51; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1.)

Prior Codifications. — 1981 Ed., § 35-1551. 1973 Ed., § 35-1361.

§ 31-1102. Definitions.

For the purposes of this chapter:

- (1) The term “insurance premium finance company” means a person engaged in the business of entering into insurance premium finance agreements.
- (2) The term “premium finance agreement” means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent or broker in payment of premiums on an insurance contract together with a service charge as authorized and limited by this chapter.
- (3) The term “licensee” means a premium finance company holding a license issued by the Commissioner under this chapter.

(Oct. 9, 1940, ch. 792, ch. III, § 52; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 29(d), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-1552.

1973 Ed., § 35-1362.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-2502.11.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1103. Licenses — Persons required to obtain; fees; other requirements.

(a) No person shall engage in the business of financing insurance premiums in the District without first having obtained a license as a premium finance company from the Commissioner. Any person who shall engage in the business of financing insurance premiums in the District without obtaining a license as provided hereunder shall, upon conviction in the Superior Court of the District of Columbia, be guilty of a misdemeanor and shall be subject to the penalties in § 31-2502.42.

(b) The annual license fee shall be \$150. Licenses may be renewed from year to year as of the 1st day of May of each year upon payment of the fee of \$150. The fee for said license shall be paid through the Commissioner to the District of Columbia Treasurer.

(c) The person to whom the license or the renewal thereof may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the Commissioner may require. The Commissioner shall have authority, at any time, to require the applicant fully to disclose the identity of all stockholders, partners, officers, and employees and he may, in his discretion, refuse to issue or renew a license in the name of any firm, partnership, or corporation if he is not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(d) Any license issued pursuant to this section shall be issued as a Financial Services endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(Oct. 9, 1940, ch. 792, ch. III, § 53; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); June 14, 1994, D.C. Law 10-128, § 403(b), 41 DCR 2096; May 21, 1997, D.C. Law 11-268, § 10(r)(3), 44 DCR 1730; Apr. 20, 1999, D.C. Law 12-261, § 2003(ii), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38, § 3(v), 50 DCR 6913.)

Prior Codifications. — 1981 Ed., § 35-1553.

1973 Ed., § 35-1363.

Effect of amendments. — D.C. Law 15-38, in subsec. (d), substituted "Financial Services endorsement to a basic business license under the basic" for "Class A Financial Services endorsement to a master business license under the master".

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(v) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

Legislative history of Law 10-128. — For legislative history of D.C. Law 10-128, see Historical and Statutory Notes following § 31-2502.41.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 12-261. — Law 12-261, the "Second Omnibus Regulatory Reform Amendment Act of 1998", was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second read-

ing on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 15-38. — Law 15-38, the “Streamlining Regulation Act of 2003”, was introduced in Council and assigned Bill No. 15-19, which was referred to Committee on Consumer and Regulatory Affairs. The

Bill was adopted on first and second readings on June 3, 2003, and July 8, 2003, respectively. Signed by the Mayor on August 11, 2003, it was assigned Act No. 15-146 and transmitted to both Houses of Congress for its review. D.C. Law 15-38 became effective on October 28, 2003.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1104. Licenses — Issuance or renewal.

(a) Upon the filing of an application and the payment of the license fee the Commissioner shall make an investigation of each applicant and shall issue a license if the applicant is qualified in accordance with this chapter. If the Commissioner does not so find, he shall, within 30 days after he has received such application, at the request of the applicant, give the applicant a full hearing.

(b) The Commissioner shall issue or renew a license as may be applied for when he is satisfied that the person to be licensed:

(1) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

(2) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied for; and

(3) If a corporation, is a corporation incorporated under the laws of the District or a foreign corporation authorized to transact business in the District.

(Oct. 9, 1940, ch. 792, ch. III, § 54; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 29(e), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-1554.

1973 Ed., § 35-1554.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1201.03.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2502.11.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1105. Licenses — Revocation, suspension or refusal to renew; penalty in lieu of revocation or suspension; right of applicant or licensee to administrative or judicial hearing.

(a) The Commissioner may revoke or suspend the license of any premium finance company when and if after investigation it appears to the Commissioner that:

(1) Any license issued to such company was obtained by fraud;

(2) There was any misrepresentation in the application for the license;

(3) The holder of such license has otherwise shown himself untrustworthy or incompetent to act as a premium finance company;

(4) Such company has violated any of the provisions of this chapter; or

(5) Such company has been rebating part of the service charge as allowed and permitted herein to any insurance agent or any employee of an insurance agent or to any other person as an inducement to the financing of any insurance policy with the premium finance company.

(b) Before the Commissioner shall revoke, suspend, or refuse to renew the license of any premium finance company, he shall give to such person an opportunity to be fully heard and to introduce evidence in his behalf. In lieu of revoking or suspending the license for any of the causes enumerated in this section, after hearing as herein provided, the Commissioner may subject such company to a penalty of not more than \$200 for each offense when in his judgment he finds that the public interest would not be harmed by the continued operation of such company. The amount of any such penalty shall be paid by such company through the office of the Commissioner to the District of Columbia Treasurer. At any hearing provided by this section, the Commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered such oath, shall be subject to the penalty of perjury.

(c) If the Commissioner refuses to issue or renew any license or if any applicant or licensee is aggrieved by any action of the Commissioner, said applicant or licensee shall have the right to a hearing and court proceeding as provided for in §§ 31-2502.35 [repealed], 31-2502.43 [repealed] and 31-2502.44 [repealed].

(Oct. 9, 1940, ch. 792, ch. III, § 55; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; May 21, 1997, D.C. Law 11-268, § 10(r)(3), 44 DCR 1730.)

Cross references. — Administrative procedure, see § 2-501 et seq.

Judicial review, see §§ 2-510 and 11-722.

Prior Codifications. — 1981 Ed., § 35-1555.

1973 Ed., § 35-1365.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1201.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1106. Records.

(a) Every licensee shall maintain records of its premium finance transactions and the said records shall be open to examination and investigation by the Commissioner. The Commissioner may at any time require any licensee to bring such records as he may direct to the Commissioner's office for examination.

(b) Every licensee shall preserve its records of such premium finance transactions, including cards used in a card system, for at least 3 years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic form shall constitute compliance with this requirement.

(Oct. 9, 1940, ch. 792, ch. III, § 56; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; May 21, 1997, D.C. Law 11-268, § 10(r)(3), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1556.

1973 Ed., § 35-1366.

Legislative history of Law 11-268 — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1107. Rules and regulations.

The Commissioner shall have authority to make and enforce such reasonable rules and regulations as may be necessary in making effective the provisions of this chapter, but such rules and regulations shall not be contrary to nor inconsistent with the provisions of this chapter.

(Oct. 9, 1940, ch. 792, ch. III, § 57; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; May 21, 1997, D.C. Law 11-268, § 10(r)(3), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1557.

1973 Ed., § 35-1367.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-1201.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1108. Form and contents of agreements.

(a) A premium finance agreement shall:

(1) Be dated, signed by or on behalf of the insured, and the printed portion thereof shall be in at least 8-point type;

(2) Contain the name and place of business of the insurance agent negotiating the related insurance contract, the name and residence or the place of business of the premium finance company to which payments are to be made, a description of the insurance contracts involved and the amount of the premium therefor; and

(3) Set forth the following items where applicable:

(A) The total amount of the premiums;

(B) The amount of the downpayment;

(C) The principal balance (the difference between subparagraphs (A) and (B) of this paragraph);

(D) The amount of the service charge;

(E) The balance payable by the insured (sum of subparagraphs (C) and (D) of this paragraph); and

(F) The number of installments required, the amount of each installment expressed in dollars, and the due date or period thereof.

(b) The items set out in subsection (a)(3) of this section need not be stated in the sequence or order in which they appear in such paragraph, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(Oct. 9, 1940, ch. 792, ch. III, § 58; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1.)

Prior Codifications. — 1981 Ed., § 35-1558. 1973 Ed., § 35-1368.

§ 31-1109. Service charges.

(a) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this chapter.

(b) The service charge is to be computed on the balance of the premiums due (after subtracting the downpayment made by the insured in accordance with the premium finance agreement) from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final installment of the premium finance agreement is payable.

(c) The service charge shall be a maximum of \$10 per \$100 per year plus an additional charge of \$20 per premium finance contract which need not be refunded upon cancellation or prepayment.

(Oct. 9, 1940, ch. 792, ch. III, § 59; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; Nov. 15, 1983, D.C. Law 5-40, § 2(a), 30 DCR 4994.)

Prior Codifications. — 1981 Ed., § 35-1559.

1973 Ed., § 35-1369.

Legislative history of Law 5-40. — Law 5-40, the "Fire and Casualty Act Amendment Act of 1983," was introduced in Council and assigned Bill No. 5-111, which was referred to

the Committee on Finance and Revenue. The Bill was adopted on first and second readings on July 5, 1983, and September 6, 1983, respectively. Signed by the Mayor on September 22, 1983, it was assigned Act No. 5-65 and transmitted to both Houses of Congress for its review.

§ 31-1110. Delinquency charges.

A premium finance agreement may provide for the payment by the insured of a delinquency charge of \$1 to a maximum of 5% of the delinquent installment which is in default for a period of 5 days or more.

(Oct. 9, 1940, ch. 792, ch. III, § 60; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; Nov. 15, 1983, D.C. Law 5-40, § 2(b), 30 DCR 4994.)

Prior Codifications. — 1981 Ed., § 35-1560.

1973 Ed., § 35-1370.

Legislative history of Law 5-40. — For legislative history of D.C. Law 5-40, see Historical and Statutory Notes following § 31-1109.

§ 31-1111. Cancellation of insurance contracts.

(a) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be canceled by the premium finance company unless such cancellation is effectuated in accordance with this section.

(b) Not less than 10 days written notice shall be mailed to the insured of the intent of the premium finance company to cancel the insurance contract unless the default is cured within such 10-day period.

(c) After expiration of such 10-day period, the premium finance company may thereafter request, in the name of the insured, cancellation of such insurance contract or contracts by mailing to the insurer a notice of cancella-

tion, and the insurance contract shall be canceled as if such notice of cancellation had been submitted by the insured himself, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a notice of cancellation to the insured at his last known address.

(d) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the 2nd business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days notice required to complete the cancellation.

(e) Whenever an insurance contract is cancelled in accordance with this section, the insurer shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company affecting the cancellation for the account of the insured or insureds.

(f) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured provided that no such refund shall be required if it amounts to less than \$1.

(g) When a default results in the cancellation of an insurance contract listed in the premium finance agreement, the premium finance agreement may provide for the payment by the insured of a cancellation charge equal to the difference between any delinquent charge imposed in respect of the installment or installments in default and \$10; provided, however, that should the cancellation notice be withdrawn prior to its effective date and the insurance coverage reinstated, the agreement may provide for payment by the insured of a reinstatement charge equal to the cancellation charge herein provided.

(Oct. 9, 1940, ch. 792, ch. III, § 61; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1; Nov. 15, 1983, D.C. Law 5-40, § 2(c), 30 DCR 4994.)

Prior Codifications. — 1981 Ed., § 35-1561.
1973 Ed., § 35-1371.

Legislative history of Law 5-40. — For legislative history of D.C. Law 5-40, see Historical and Statutory Notes following § 31-1109.

CASE NOTES

ANALYSIS

Notice.
Remedies.

Notice.

Insured was not entitled to notice of cancellation of policy from insurer, where the insured had executed a power of attorney and interposed a premium finance company between himself and the insurer, and where the cancellation took place at the request of the finance company. D.C. Code 1981, §§ 35-1561, 35-

1561(c), 35-2109, 35-2109(b). *Atwater v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

Remedies.

A law protecting consumers from arbitrary cancellation of their insurance policies was a consumer protection law, subject to remedies under the Consumer Protection Procedures Act. D.C. Code 1981, §§ 28-3901 to 28-3908, 35-1561. *Atwater v. District of Columbia Dep't*

of Consumer & Regulatory Affairs, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

§ 31-1112. Validity of agreements as secured transactions.

No filing of the premium finance agreement shall be necessary to perfect the validity of such agreement as a secured transaction as against creditors, subsequent purchasers, pledges, and encumbrances, successors, or assigns.

(Oct. 9, 1940, ch. 792, ch. III, § 62; Apr. 18, 1966, 80 Stat. 126, Pub. L. 89-403, § 1.)

Prior Codifications. — 1981 Ed., § 35-1562. 1973 Ed., § 35-1372.

CHAPTER 11A. INSURANCE PRODUCERS.

Sec.	Sec.
31-1131.01. Short title.	31-1131.08a. Changes of name, residency, or address.
31-1131.02. Definitions.	31-1131.09. Exemption from examination and prelicensing education.
31-1131.03. License required.	31-1131.10. Assumed names.
31-1131.04. Exceptions to licensing.	31-1131.11. Temporary licensing.
31-1131.05. Examination prior to licensure.	31-1131.12. License denial, nonrenewal, suspension, or revocation.
31-1131.05a. Pre-licensing education.	31-1131.13. Commissions.
31-1131.05b. Pre-licensing education for title insurers.	31-1131.14. Appointments.
31-1131.06. Application for resident insurance producer license.	31-1131.15. Notification to Commissioner of termination.
31-1131.06a. Fingerprinting.	31-1131.16. Reciprocity.
31-1131.07. License.	31-1131.17. Reporting of actions.
31-1131.07a. Term of license; renewal.	31-1131.18. Regulations.
31-1131.07b. Continuing education.	31-1131.19. Transition.
31-1131.08. Nonresident licensing.	

§ 31-1131.01. Short title.

This chapter may be cited as “the Producer Licensing Act of 2002.”

(Mar. 27, 2003, D.C. Law 14-264, § 1, 50 DCR 260.)

Legislative history of Law 14-264. — Law 14-264, the “Producer Licensing Act of 2002”, was introduced in Council and assigned Bill No. 14-223, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings

on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 23, 2002, it was assigned Act No. 14-561 and transmitted to both Houses of Congress for its review. D.C. Law 14-264 became effective on March 27, 2003.

§ 31-1131.02. Definitions.

For the purposes of this chapter, the term:

(1) “Business entity” means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(2) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(2A) “Department” means the Department of Insurance, Securities, and Banking, established by § 31-102.

(3) “District” means the District of Columbia.

(4) “Home state” means the District or any state or territory of the United States in which an insurance producer:

(A) Maintains his or her principal place of residence or principal place of business; and

(B) Is licensed as a resident insurance producer.

(4A) “Individual” means a natural person.

(5) “Insurance” means any of the lines of authority enumerated in § 31-1131.07(a).

(6) “Insurance producer” means a person required to be licensed in the District to sell, solicit, or negotiate insurance under this chapter.

(7) “Insurer” means a company offering protection through the sale of an insurance policy to an insured.

(8) “License” means a document issued by the Commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document.

(9) Repealed.

(10) Repealed.

(11) “Limited line of insurance” means a line of insurance:

(A) Enumerated in § 31-1131.07(a)(10)(A), (B), (C), (D), or (E);

(B) Established by the Commissioner pursuant to § 31-1131.07(a)(10)(F); or

(C) Recognized by the Commissioner pursuant to § 31-1131.07(a)(10)(G).

(12) “Limited lines insurance producer” means a person authorized by the Commissioner to sell, solicit, or negotiate a limited line of insurance.

(13) “NAIC” means the National Association of Insurance Commissioners.

(14) “Negotiate” means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract; provided, that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(14A) “Nonresident insurance producer” means an insurance producer whose home state is not the District.

(15) “Person” means an individual or a business entity.

(15A) “Resident insurance producer” means an insurance producer whose home state is the District.

(16) “Sell” means to sell or exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(17) “Solicit” means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(18) “Terminate” means the cancellation of the relationship between an insurance producer and an insurer or the termination of a producer’s authority to transact insurance.

(19) “Uniform Business Entity Application” means the current version of the NAIC Uniform Application for Business Entity Insurance License/Registration.

(20) “Uniform Individual Application” means the current version of the NAIC Uniform Application for Individual Insurance Producer License.

(Mar. 27, 2003, D.C. Law 14-264, § 2, 50 DCR 260; June 11, 2004, D.C. Law 15-166, § 4(g)(1), 51 DCR 2817; Apr. 13, 2005, D.C. Law 15-354, § 43, 52 DCR 2638; Mar. 2, 2007, D.C. Law 16-191, § 44(b), 53 DCR 6794; May 13, 2008, D.C. Law 17-155, § 2(a), 55 DCR 3683.)

Effect of amendments. — D.C. Law 15-166, in par. (2), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

D.C. Law 15-354, in par. (2), validated a previously made technical correction.

D.C. Law 16-191, in par. (2), validated a previously made technical correction.

D.C. Law 17-155 added pars. (2A), (4A), (14A), (15A); rewrote pars. (4), (5), (6), (11), (18), (19), and (20); and repealed pars. (9) and (10).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(g)(1) of

Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 16-191. — Law 16-191, the “Technical Amendments Act of 2006”, was introduced in Council and assigned Bill No. 16-760, which was referred to the Committee of the whole. The Bill was adopted on first and second readings on June 20, 2006, and July 11, 2006, respectively. Signed by the

Mayor on July 31, 2006, it was assigned Act No. 16-475 and transmitted to both Houses of Congress for its review. D.C. Law 16-191 became effective on March 2, 2007.

Legislative history of Law 17-155. — Law 17-155 the “Producer Licensing Amendment Act of 2008”, was introduced in Council and assigned Bill No. 17-252 which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on February 5, 2008, and March 4, 2008, respectively. Signed by the Mayor on March 19, 2008, it was assigned Act No. 17-327 and transmitted to both Houses of Congress for its review. D.C. Law 17-155 became effective on May 13, 2008.

§ 31-1131.03. License required.

(a) A person shall not sell, solicit, or negotiate insurance in the District for any class of insurance unless the person is licensed for that line of authority in accordance with this chapter. The license itself shall not create any authority in the licensee to represent or commit an insurance carrier.

(b)(1) A person who maintains his or her principal place of residence and principal place of business in the District shall apply for a resident insurance producer license.

(2) A person who maintains his or her principal place of residence and principal place of business outside the District shall apply for a nonresident insurance producer license.

(3) A person who maintains either, but not both, his or her principal place of residence or principal place of business in the District shall apply for:

(A) A nonresident insurance producer license if the person is licensed as a resident insurance producer in another state; or

(B) A resident insurance producer license if the person is not licensed as a resident insurance producer in another state.

(Mar. 27, 2003, D.C. Law 14-264, § 3, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(b), 55 DCR 3683.)

Effect of amendments. — D.C. Law 17-155 designated the existing text as subsec. (a); and added subsec. (b).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.04. Exceptions to licensing.

(a) This chapter shall not require an insurer to obtain an insurance producer license. For the purposes of this section, the term “insurer” shall not include an insurer’s officers, directors, employees, subsidiaries, or affiliates.

(b) The following persons shall not be required to be licensed as an insurance producer:

(1) An officer, director, or employee of an insurer or of an insurance producer; provided, that:

(A) The officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in the District; and

(B)(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers, the person's activities are limited to providing technical advice and assistance to licensed insurance producers, and the person's activities do not include the sale, solicitation, or negotiation of insurance;

(2) If no commission is paid for the service, a person who:

(A) Secures and furnishes information for the purpose of:

(i) Selling group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and health insurance;

(ii) Enrolling individuals under plans; or

(iii) Issuing certificates under plans or otherwise assisting in administering plans; or

(B) Performs administrative services related to mass-marketed property and casualty insurance;

(3) An employer or association, its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer; provided, that the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(4) Employees of insurers or organizations employed by insurers who are:

(A) Engaging in:

(i) The inspection, rating, or classification of risks; or

(ii) The supervision of the training of insurance producers; and

(B) Are not individually engaged in the sale, solicitation, or negotiation of insurance;

(5) A person whose activities in the District are limited to advertising, without the intent to solicit insurance in the District, through communications in printed publications or other forms of electronic mass media; provided, that the person does not sell, solicit, or negotiate insurance that would insure risks of persons residing in, located in, or activities to be performed in the District;

(6) A person who is not a resident of the District who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; provided, that the person is otherwise licensed as an insurance

producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(7) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer; provided, that the employee does not sell or solicit insurance or receive a commission.

(Mar. 27, 2003, D.C. Law 14-264, § 4, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

§ 31-1131.05. Examination prior to licensure.

(a) An individual applying for a resident insurance producer license shall pass a written examination unless the individual is:

(1) Applying for a limited lines insurance producer license or a license in the surplus lines line of authority; or

(2) Exempt from examination under § 31-1131.05b or § 31-1131.09.

(a-1) The examination required by subsection (a) of this section shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and regulations of the District.

(b) The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting a nonrefundable fee for the examination.

(c) Each individual applying for an examination shall remit a nonrefundable fee for the examination as prescribed by the Commissioner.

(d) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination. The individual shall remit all required fees and forms before being rescheduled for another examination.

(Mar. 27, 2003, D.C. Law 14-264, § 5, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(c), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18-223, § 2166(a), 57 DCR 6242.)

Effect of amendments. — D.C. Law 17-155 rewrote the section name line which had read as follows: “Application for examination”; rewrote subsec. (a); added subsec. (a-1); and, in subsec. (d), substituted “may reapply for an examination. The individual shall remit” for “shall reapply for an examination and remit”. Prior to amendment, subsec. (a) read as follows: “(a) A resident individual applying for an insurance producer license shall pass a written examination unless exempt under § 31-1131.09. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and

responsibilities of an insurance producer, and the insurance laws and regulations of the District. Examinations required by this section shall be developed and conducted under rules and regulations promulgated by the Commissioner.”

D.C. Law 18-223 substituted “§ 31-1131.05b or § 31-1131.09” for “§ 31-1131.09”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2166(a) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 14-264. — For

Law 14-264, see notes following § 31-1131.01.
Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.05a. Pre-licensing education.

(a) The Commissioner may require, by rule, that an individual, other than an applicant for a title insurance producer license, complete a pre-licensing course of study before:

- (1) Taking the examination required by § 31-1131.05; or
- (2) Applying for an insurance producer license.

(b) An insurer that sells, solicits, or negotiates a limited line of insurance in the District shall provide to each individual whose duties will include selling, soliciting, or negotiating the insurer's limited line of insurance in the District a program of instruction that is approved by the Commissioner. The insurer shall provide the program of instruction to the individual prior to the individual's application for licensure as a limited lines insurance producer.

(Mar. 27, 2003, D.C. Law 14-264, § 5a, as added May 13, 2008, D.C. Law 17-155, § 2(d), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18-223, § 2166(b), 57 DCR 6242.)

Effect of amendments. — D.C. Law 18-223, in subsec. (a), substituted "individual, other than an applicant for a title insurance producer license, complete" for "individual complete".

Emergency legislation. — For temporary (90 day) amendment of section, see § 2166(b) of

Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.05b. Pre-licensing education for title insurers.

(a) The Commissioner shall require, by rule, that an individual, not exempt under subsections (b), (c), or (d) of this section, complete a pre-licensing course of study before:

- (1) Taking the examination required by § 31-1131.05; or
- (2) Applying for an insurance producer license.

(b) An attorney who holds a license to practice law in any state or the District of Columbia shall be exempt from pre-licensing course of study requirements and examination requirements.

(c) A title agent insurance applicant who provides certification from a title insurance insurer that the agent has had signing authority on policies or title insurance commitments for the past 3 years relating to properties located within the District of Columbia shall be exempt from the pre-licensing course of study requirements and the examination requirements; provided, that the certification is submitted to the Commissioner within one year after September 24, 2010.

(d) A full-time employee of a title insurer shall be exempt from the pre-licensing course of study requirement.

(e) The District of Columbia Land Title Association, or other organization designated by the Commissioner by rule, shall provide to each individual

whose duties will include selling, soliciting, or negotiating a title insurer's limited line of title insurance in the District a program of instruction that is approved by the Commissioner. The insurer shall provide the program of instruction to the individual prior to the individual's application for licensure as a limited lines insurance producer.

(Mar. 27, 2003, D.C. Law 4-264, § 5b, as added Sept. 24, 2010, D.C. Law 18-223, § 2166(3), 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition of section, see § 2166(3) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.06. Application for resident insurance producer license.

(a) An individual applying for a resident insurance producer license shall make application to the Commissioner on the Uniform Individual Application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Commissioner shall find that the individual:

(1) Is at least 18 years of age;

(2) Has not committed any act that is a ground for denial, suspension, or revocation set forth in § 31-1131.12; provided, that if an applicant for a title insurance producer license has been convicted of any such act and 10 years have elapsed since the individual's conviction, and a title insurer submits written verification that the person has had authority from the title insurer to issue title insurance policies or commitments related to real or personal property within the District of Columbia for a period of not less than 3 years prior to the application for license, such act or conviction may be considered not to apply by the Commissioner;

(3) If required by the Commissioner, has completed a pre-licensing course of study for the lines of authority for which the person has applied;

(4) Has paid the fees prescribed by the Commissioner; and

(5) Unless exempt under § 31-1131.09, has successfully passed the examinations for the lines of authority for which the person has applied.

(b) A business entity applying for a resident business entity producer license shall make application to the Commissioner on the Uniform Business Entity Application. Before approving the application, the Commissioner shall find that the business entity has:

(1) Paid the fees prescribed by the Commissioner; and

(2) Designated a licensed individual producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of the District.

(c) The Commissioner may require any documents reasonably necessary or appropriate to verify the information contained in an application.

(d) Repealed.

(Mar. 27, 2003, D.C. Law 14-264, § 6, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(e), 55 DCR 3683; Mar. 25, 2009, D.C. Law 17-353, § 234, 56 DCR 1117; Sept. 24, 2010, D.C. Law 18-223, § 2166(c), 57 DCR 6242.)

Effect of amendments. — D.C. Law 17-155, in the section name line, substituted “resident insurance producer” for “for”; in subsec. (a), substituted “An individual applying for a resident insurance” for “A person applying for an insurance”, and substituted “Uniform Individual Application” for “Uniform Application”; in subsec. (b), substituted “applying for a resident business entity producer license shall make application to the Commissioner on” for “acting as an insurance producer shall obtain an insurance producer license. Application shall be made using”; and repealed subsec. (d), which had read as follows: “(d) An insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that is approved by the Commissioner.”

D.C. Law 17-353, in the section heading, inserted “for”.

D.C. Law 18-223, in subsec. (a)(2), substituted “set forth in § 31-1131.12; provided, that if an applicant for a title insurance producer

license has been convicted of any such act and 10 years have elapsed since the individual’s conviction, and a title insurer submits written verification that the person has had authority from the title insurer to issue title insurance policies or commitments related to real or personal property within the District of Columbia for a period of not less than 3 years prior to the application for license, such act or conviction may be considered not to apply by the Commissioner” for “set forth in § 31-1131.12”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2166(c) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.06a. Fingerprinting.

(a) An individual applying for a resident insurance producer license under this chapter (except for an individual applying only for a limited lines insurance producer license) and each officer, director, partner of, and owner of a controlling interest in, a business entity applying for a resident insurance producer license under this chapter (except for a business entity applying only for a limited lines insurance producer license) shall submit to the Commissioner the individual’s fingerprints along with the individual’s name, address, and written consent to the performance of a criminal history record background check.

(b) The Commissioner may require, by rule, that an individual applying only for a resident limited lines insurance producer license and each officer, director, partner of, and owner of a controlling interest in, a business entity applying only for a resident limited lines insurance producer license, shall submit to the Commissioner his or her fingerprints along with his or her name, address, and written consent to the performance of a criminal history record background check.

(c) The Commissioner may exchange the fingerprints and other information with, and receive criminal history record information from, the Metropolitan Police Department and the Federal Bureau of Investigation for the purposes of facilitating determinations regarding eligibility for licensure under this chapter.

(d) The individual or business entity applying for licensure shall bear the cost of the criminal history record background check and all costs of administering and processing the background check.

(Mar. 27, 2003, D.C. Law 14-264, § 6a, as added May 13, 2008, D.C. Law 17-155, § 2(f), 55 DCR 3683.)

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.07. License.

(a) Unless denied licensure under § 31-1131.12, persons who have met the requirements of §§ 31-1131.05 and 31-1131.06 shall be issued a resident insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of insurance permitted under law or regulations:

(1) Life, consisting of insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;

(2) Accident and health or sickness, consisting of insurance coverage for sickness, bodily injury, or accidental death, including benefits for disability income;

(3) "Property, consisting of insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) Casualty, consisting of insurance coverage against legal liability, including that for death, injury, or disability, or damage to real or personal property;

(5) Variable life and variable annuity, consisting of insurance coverage provided under variable life insurance contracts and variable annuities;

(6) Personal lines, consisting of property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) Repealed;

(8) Bail bonds, consisting of insuring or guaranteeing that a person will attend court when required, or will obey the orders or judgment of a court, as a condition to the release of the person from confinement;

(9) Surplus lines, consisting of insurance coverage provided pursuant to § 31-2502.40(a) by a company not otherwise authorized to do business in the District; and

(10) Any of the following limited lines of insurance:

(A) Car rental;

(B) Credit;

(C) Crop;

(D) Surety;

(E) Travel;

(F) A limited line of insurance established by the Commissioner by rule; and

(G) A line of insurance the Commissioner recognizes as a limited line of insurance for the purposes of complying with § 31-1131.08(e).

(a-1) A person shall not be issued a license in the bail bonds or surplus lines line of insurance unless the person holds, or is simultaneously issued, a license in the property or casualty line of insurance.

(b) Repealed.

(c) Repealed.

(d) Repealed.

(e) The license shall contain the licensee's name, address, personal identification number, the date of issuance, the lines of authority, the expiration date, and any other information the Commissioner considers useful or necessary.

(f) Repealed.

(g) To assist in the performance of the Commissioner's duties, the Commissioner may contract with a third party, including the NAIC, or its affiliates or subsidiaries, to perform any ministerial functions, including the collection of fees, related to producer licensing that the Commissioner may consider appropriate.

(Mar. 27, 2003, D.C. Law 14-264, § 7, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(g), 55 DCR 3683.)

Effect of amendments. — D.C. Law 17-155 rewrote the section.

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1031.02.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.07a. Term of license; renewal.

(a) An initial individual insurance producer license issued after May 13, 2008, and the first renewal after May 13, 2008, of an individual insurance producer license initially issued before May 13, 2008, shall expire on the last day of the birth month of the producer that falls not less than 18 months and not more than 29 months after the effective date of the license.

(b) An initial business entity insurance producer license issued after May 13, 2008, and the first renewal after May 13, 2008, of a business entity insurance producer license initially issued before May 13, 2008, shall expire on the May 31 that falls not less than 18 months and not more than 29 months after the effective date of the license.

(c) A renewal of an existing license shall expire 2 years after the expiration date of the license period; provided, that the first renewal after May 13, 2008, of a license initially issued before May 13, 2008, shall be governed by subsections (a) and (b) of this section.

(d) A person shall apply for or request renewal of a license on a form, or through such means, as may be prescribed by the Commissioner.

(e) The Commissioner shall renew an insurance producer license if:

(1) The producer applies for or requests license renewal on the form, or through such means, prescribed by the Commissioner;

(2) All fees prescribed by the Commissioner are paid;

(3) If the producer is a resident insurance producer:

(A) The continuing education requirements, if any, have been met;

(B) The license is not subject to non-renewal under § 31-1131.12; and

(C) The person has submitted a full set of fingerprints, if required by law or rule; and

(4) If the producer is a nonresident producer, he or she continues to be licensed as a resident producer, in good standing, in his or her home state.

(f) An individual insurance producer who allows his or her license to lapse may, within one year after the expiration date of the license, reinstate the same license without the necessity of passing a written examination; provided, that the producer shall pay a penalty in the amount of twice the unpaid renewal fee.

(g) An insurance producer who is unable to comply with the license renewal procedures due to military service or some other extenuating circumstance may request a waiver of those procedures. The insurance producer may also request a waiver of any examination requirement or any other penalty or sanction imposed for failure to comply with renewal procedures.

(Mar. 27, 2003, D.C. Law 14-264, § 7a, as added May 13, 2008, D.C. Law 17-155, § 2(h), 55 DCR 3683.)

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.07b. Continuing education.

(a) A title insurance producer shall fulfill the following continuing education requirements:

(1) Eight hours per year, of which not more than 4 hours may be completed by computer or video-based education; or

(2) If the title insurance producer is an attorney, 4 hours per year in courses related to real estate and continuing education courses approved by the Commissioner by rule.

(b) The Commissioner may establish continuing education requirements for resident insurance producers.

(Mar. 27, 2003, D.C. Law 14-264, § 7b, as added May 13, 2008, D.C. Law 17-155, § 2(h), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18-223, § 2166(d), 57 DCR 6242.)

Effect of amendments. — D.C. Law 18-223 rewrote the section, which had read as follows: “The Commissioner may establish continuing education requirements for resident insurance producers.”

Emergency legislation. — For temporary (90 day) amendment of section, see § 2166(d) of

Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.08. Nonresident licensing.

(a) A person may request a nonresident license if the person is licensed as a resident insurance producer in another state.

(a-1) A person requesting a nonresident insurance producer license shall

make his or her request on a form, or through such means, prescribed by the Commissioner.

(a-2) Unless denied licensure under § 31-1131.12 or granted a resident insurance producer license by meeting the requirements of §§ 31-1131.05 and 31-1131.06, a nonresident person shall receive a nonresident insurance producer license if:

(1) The person is currently licensed as a resident and in good standing in his or her home state;

(2) The person has submitted the proper request for a nonresident insurance producer license and has paid the fees as prescribed by the Commissioner; and

(3) The person has submitted or transmitted to the Commissioner a completed NAIC Uniform Application or the application for licensure that the person submitted to his or her home state.

(b) The Commissioner may verify the insurance producer's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

(c) Repealed.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in his or her home state shall receive a nonresident surplus lines producer license under subsection (a) of this section. Except as provided in subsection (a) of this section, this section shall not amend or supersede any provision of §§ 31-2502.39 and 31-2502.40.

(e) Notwithstanding any other provision of this chapter, a person licensed as a limited line insurance producer in his or her home state shall receive a nonresident limited lines insurance producer license under subsection (a) of this section granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, the term "limited line insurance" means any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines under § 31-1131.07(a)(1) through (6).

(f) An applicant may qualify for a license under this chapter as a nonresident only if the applicant holds an equivalent license in the applicant's home state. A license issued to a nonresident of the District shall grant the same rights and privileges as a resident licensee.

(g) A nonresident title insurance producer shall have a registered agent in the District of Columbia at the time of application for a title insurance producer license and shall maintain a registered agent in the District of Columbia as a condition of licensing under this section.

(Mar. 27, 2003, D.C. Law 14-264, § 8, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(i), 55 DCR 3683; Sept. 24, 2010, D.C. Law 18-223, § 2166(e), 57 DCR 6242.)

Effect of amendments. — D.C. Law 17-155 rewrote subsec. (a); added subsecs. (a-1), (a-2), and (f); repealed subsec. (c); and, in subsec. (e), substituted "limited lines insurance" for "limited line credit insurance or other type of lim-

ited lines" and substituted "nonresident limited lines insurance" for "nonresident limited lines".

D.C. Law 18-223 added subsec. (g).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2166(e) of

Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-1131.08a. Changes of name, residency, or address.

(a) A licensee shall inform the Commissioner of a change of the licensee's residential or business address within 30 days of the change of address. A nonresident insurance producer who moves from one state to another state or a resident insurance producer who moves from the District to another state shall file a change of address and provide certification from the new resident state within 30 days after the change of residence. No fee or license application shall be required.

(b) A licensee shall inform the Commissioner of a change of the licensee's legal or corporate name within 30 days after the change of name.

(c) Failure to timely inform the Commissioner of a change in legal name or address shall result in a penalty as prescribed by the Commissioner.

(d) A person licensed as an insurance producer in another state who moves to the District shall make application within 90 days of establishing legal residence to become a resident licensee under § 31-1131.06 unless the person maintains his principal place of business in another state and the person has a resident insurance producer license in that state.

(Mar. 27, 2003, D.C. Law 14-264, § 8a, as added May 13, 2008, D.C. Law 17-155, § 2(j), 55 DCR 3683.)

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.09. Exemption from examination and prelicensing education.

(a) An individual who applies for a resident insurance producer license in the District shall not be required to complete any prelicensing education (if prelicensing education is required by the Commissioner pursuant to § 31-1131.05a) or examination if:

(1) The individual is currently licensed for the same line of authority in another state; or

(2)(A) The application is received within 90 days of the cancellation of the applicant's previous license for the same lines of authority in another state; and

(B)(i) The prior state issues a certification that, at the time of cancellation, the person was in good standing in that state; or

(ii) The state's producer database records, maintained by the NAIC, its affiliates, or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) Repealed.

(c) Repealed.

(d) Repealed.

(e) Repealed.

(Mar. 27, 2003, D.C. Law 14-264, § 9, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(k), 55 DCR 3683.)

Effect of amendments. — D.C. Law 17-155 rewrote the section.

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.10. Assumed names.

An insurance producer doing business under any name other than the producer's legal name shall notify the Commissioner prior to using the assumed name.

(Mar. 27, 2003, D.C. Law 14-264, § 10, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

§ 31-1131.11. Temporary licensing.

(a) The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if the Commissioner determines that the temporary license shall be necessary for the servicing of an insurance business for:

(1) The surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or acquires a mental or physical disability to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(2) A member or employee of a business entity licensed as an insurance producer upon the death or disability of an individual designated in the business entity application or the license;

(3) The designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or

(4) Any other circumstance that the Commissioner determines that the public interest will best be served by the issuance of the license.

(b) The Commissioner may, by order, limit the authority of a temporary licensee in any way which the Commissioner considers to be necessary to protect insureds and the public. The Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed insurance producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The Commissioner may, by order, revoke a temporary license if the interests of the insureds or the public are endangered. A temporary license shall not continue after the owner or the personal representative disposes of the business.

(Mar. 27, 2003, D.C. Law 14-264, § 11, 50 DCR 260; Apr. 24, 2007, D.C. Law 16-305, § 40, 53 DCR 6198.)

Effect of amendments. — D.C. Law 16-305, in subsec. (a)(1), substituted “acquires a mental or physical disability” for “becomes mentally or physically disabled”.

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 16-305. — Law 16-305, the “People First Respectful Language Modernization Act of 2006”, was introduced in

Council and assigned Bill No. 16-664, which was referred to Committee on the Whole. The Bill was adopted on first and second readings on June 20, 2006, and July 11, 2006, respectively. Signed by the Mayor on July 17, 2006, it was assigned Act No. 16-437 and transmitted to both Houses of Congress for its review. D.C. Law 16-305 became effective on April 24, 2007.

§ 31-1131.12. License denial, nonrenewal, suspension, or revocation.

(a) The Commissioner may refuse to issue an insurance producer license; place an insurance producer on probation; suspend, revoke, or refuse to renew an insurance producer’s license; levy a civil penalty in accordance with subsection (d) of this section; issue subpoenas and administer oaths; or take any combination of these actions if an insurance producer or an applicant for an insurance producer license:

(1) Provides incorrect, misleading, incomplete, or materially untrue information in the license application;

(2) Violates any insurance laws or any regulation, subpoena, or order of the Commissioner or of another state’s insurance commissioner;

(3) Obtains, or attempts to obtain, a license through misrepresentation or fraud;

(4) Improperly withholds, misappropriates, or converts any monies or properties received in the course of doing insurance business;

(5) Intentionally misrepresents the terms of an actual or proposed insurance contract or application for insurance;

(6) Is convicted of a felony;

(7) Admits committing, or is found to have committed, any insurance unfair trade practice or fraud;

(8) Uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in the District or elsewhere;

(9) Has an insurance producer license, or its equivalent, denied, suspended, or revoked in any state or territory of the United States, province of Canada, or other foreign country;

(10) Forges another’s name to an application for insurance or to any document related to an insurance transaction;

(11) Improperly uses notes or any other reference material to complete, or otherwise cheats on, an examination for an insurance license;

(12) Knowingly accepts insurance business from an individual who is not licensed;

(13) Fails to comply with an administrative or court order imposing a child support obligation;

(14) Fails to pay District income tax or comply with any administrative or court order directing payment of District income tax;

(15) Repealed; or

(16) Is found to have misrepresented satisfactory completion of, or improperly used notes or other reference material to complete, or otherwise cheats on, an examination in a prelicensure or continuing education course.

(a-1) In addition to the reasons set forth in subsection (a) of this section, the Commissioner may place a business entity insurance producer on probation; suspend, revoke, or refuse to renew a business entity insurance producer's license; or levy a civil penalty against a business entity insurance producer if:

(1) One or more of the partners, officers, or managers acting on behalf of the business entity knew or should have known of the occurrence of a license violation;

(2) The violation was not reported to the Commissioner; and

(3) Corrective action was not taken.

(b)(1) Except as provided in paragraph (2) of this subsection, the Commissioner shall not place an insurance producer on probation; suspend, revoke, or refuse to renew an insurance producer's license; or levy a civil penalty against an insurance producer without first providing the following notice and opportunity for hearing to the applicant or licensee. The Commissioner shall notify the applicant or licensee, in writing, of the proposed action and the reason for the proposed action. The Commissioner shall also inform the applicant or licensee, in writing, that the applicant or licensee may, within 30 days after the date of the Commissioner's notice, request a hearing to determine whether the proposed action should be taken. If a hearing is requested, the Commissioner, or a designee of the Commissioner, shall hold the hearing within 30 days after the date of receipt by the Commissioner of the written request, and the Commissioner shall not, except as provided in paragraph (2) of this subsection, take the proposed action before the close of the hearing.

(2)(A) If the Commissioner determines that further transaction of business by a producer would be hazardous to the public or the policyholders or creditors of the producer, the Commissioner may revoke or suspend the license of the producer without giving notice or prior opportunity for a hearing; provided, that the Commissioner shall provide to the producer the opportunity for a hearing within 30 days after the effective date of the order of the revocation or suspension.

(B) The Commissioner may refuse to issue an initial insurance producer license without giving notice or prior opportunity for a hearing; provided, that the Commissioner shall provide to the applicant the opportunity for a hearing within 30 days after the date of the denial.

(3) In a hearing under this subsection, the Commissioner may administer oaths to witnesses and issue subpoenas for witnesses and documents. A witness testifying falsely under oath shall be subject to the penalties of perjury. The Commissioner's authority to issue subpoenas shall not be limited to hearings if the Commissioner determines that the issuance of a subpoena is useful or necessary to protect the public interest. If a person refuses to obey a subpoena issued by the Commissioner, the Commissioner may petition the

Superior Court of the District of Columbia (“Superior Court”) to enforce the subpoena, and the Superior Court may issue an order requiring the person to appear and testify before the Commissioner or produce documents. A person failing to obey the Superior Court’s order may be held in contempt of court.

(c) Repealed.

(d) In addition to or in lieu of any applicable denial of renewal, suspension, or revocation of a license, the Commissioner may, after a hearing, take any of the following actions:

(1) Impose a civil penalty not to exceed \$5,000; or

(2) Require restitution to any person who has suffered financial injury or damage as a result of the violation of the license.

(d-1) A person affected or aggrieved by an order, ruling, proceeding, or action of the Commissioner, or any person acting on behalf of the Commissioner, under this section may contest the validity of the same in any court of competent jurisdiction by appeal or through any other appropriate proceedings. In any proceeding or appeal, the Commissioner shall not be:

(1) Taxed with any costs;

(2) Required to give any supersedeas bond or security for costs or damages;

(3) Subject to suit or action or liable for any judgment or decree for any damages, loss, or injury claimed by any person on any appeal taken; or

(4) Required to make any deposit for costs or pay for any service to the clerks of any court or to any marshal of the United States, except as may be inconsistent with law.

(e) Notwithstanding the revocation, surrender, or lapse of a license, the Commissioner may enforce the provisions of, and impose any penalty or remedy authorized by, this chapter or any other District law relating to insurance against any person who is under investigation for or charged with a violation of this chapter or any other District law relating to insurance.

(Mar. 27, 2003, D.C. Law 14-264, § 12, 50 DCR 260; Mar. 8, 2006, D.C. Law 16-55, § 2, 53 DCR 7; May 13, 2008, D.C. Law 17-155, § 2(l), 55 DCR 3683.)

Effect of amendments. — D.C. Law 16-55, in the section heading, inserted “, suspension,”; rewrote the lead-in language of subsec. (a); designated the existing text of subsec. (b)(1) as subsec. (b)(1)(A); added subsec. (b)(1)(B); and added subsec. (c). Prior to amendment, the lead-in language of subsec. (a) read as follows: “(a) The Commissioner may place an insurance producer on probation; suspend, revoke, or refuse to issue or renew an insurance producer’s license; may levy a civil penalty in accordance with subsection (f) of this section; or take any combination of these actions if an insurance producer.”

D.C. Law 17-155 rewrote the section.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Producer Summary Suspension Temporary Amendment Act of 2004 (D.C. Law 15-

259, March 17, 2009, law notification 52 DCR 4371).

For temporary (225 day) amendment of section, see § 2 of Producer Summary Suspension Temporary Amendment Act of 2005 (D.C. Law 16-47, February 9, 2006, law notification 53 DCR 1455).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Producer Summary Suspension Emergency Amendment Act of 2004 (D.C. Act 15-548, October 26, 2004, 51 DCR 10332).

For temporary (90 day) amendment of section, see § 2 of Producer Summary Suspension Congressional Review Emergency Amendment Act of 2005 (D.C. Act 16-18, February 17, 2005, 52 DCR 2962).

For temporary (90 day) amendment of section, see § 2 of Producer Summary Suspension

Emergency Amendment Act of 2005 (D.C. Act 16-192, October 28, 2005, 52 DCR 10029).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 16-55. — Law 16-55, the “Producer Summary Suspension Amendment Act of 2005”, was introduced in Council and assigned Bill No. 16-202 which was referred to the Committee on Consumer and

Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 2005, and December 6, 2005, respectively. Signed by the Mayor on December 22, 2005, it was assigned Act No. 16-217 and transmitted to both Houses of Congress for its review. D.C. Law 16-55 became effective on March 8, 2006.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.13. Commissions.

(a) An insurer or insurance producer shall not pay a commission, service fee, brokerage fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in the District if that person is required to be licensed under this chapter and is not licensed.

(b) A person shall not accept a commission, service fee, brokerage fee, or other valuable consideration for selling, soliciting, or negotiating insurance in the District if that person is required to be licensed under this chapter and is not licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in the District if the person was required to be licensed under this chapter at the time of the sale, solicitation, or negotiation and was licensed at that time.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerage fees, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in the District unless the payment would violate this chapter or any other District law relating to insurance.

(Mar. 27, 2003, D.C. Law 14-264, § 13, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

§ 31-1131.14. Appointments.

(a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer shall not be required to become appointed.

(b) To appoint an insurance producer as its agent, the appointing insurer shall file, on a form prescribed by the Commissioner, a notice of appointment within 30 days from the date that the agency contract is executed or the first insurance application is submitted.

(c) Upon receipt of the notice of appointment, the Commissioner shall verify, within 10 days, that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the Commissioner shall notify the insurer within 5 days of the determination.

(d) An insurer shall pay an appointment fee, in the amount and on or before the date prescribed by the Commissioner, for each insurance producer appointed by the insurer.

(e) An insurer shall pay a renewal appointment fee in the amount and on or before the date prescribed by the Commissioner.

(Mar. 27, 2003, D.C. Law 14-264, § 14, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

§ 31-1131.15. Notification to Commissioner of termination.

(a) An insurer, or authorized representative of the insurer, that terminates the appointment, employment, contract, or other insurance business relationship with an insurance producer shall notify the Commissioner within 30 days after the effective date of the termination, on a form prescribed by the Commissioner, if the reason for termination is set forth in § 31-1131.12 or the insurer has knowledge that the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in set forth in § 31-1131.12. Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the insurance producer.

(b) An insurer, or authorized representative of the insurer, that terminates the appointment, employment, or contract with an insurance producer for any reason not set forth in § 31-1131.12, shall notify the Commissioner within 30 days after the effective date of the termination on a form prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(c) The insurer, or the authorized representative of the insurer, shall promptly notify the Commissioner, on a form prescribed by the Commissioner, if, upon further review or investigation, the insurer discovers additional information that would have been reported to the Commissioner in accordance with subsection (a) of this section.

(d)(1) Within 15 days after making the notification required by subsections (a), (b), and (c) of this section, the insurer shall mail a copy of the notification to the insurance producer at his or her last known address. If the insurance producer is terminated for cause for any of the reasons set forth in § 31-1131.12, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(2) Within 30 days after the insurance producer has received the original or additional notification, the insurance producer may file written comments concerning the substance of the notification with the Commissioner. The insurance producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer. The comments shall become a part of the Commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the insurance producer as permitted under subsection (f) of this section.

(e)(1) In the absence of actual malice, an insurer, the authorized represen-

tative of the insurer, an insurance producer, the Commissioner, an organization of which the Commissioner is a member and that compiles the information and makes it available to other insurance commissioners or regulatory or law enforcement agencies, or their agents or employees shall not be subject to civil liability as a result of:

(A) A statement or information required by or provided under this section or any information relating to any statement that may be requested in writing by the Commissioner from an insurer or an insurance producer; or

(B) A statement by a terminating insurer or insurance producer to an insurer or insurance producer limited solely and exclusively to whether a termination for cause under subsection (a) of this section was reported to the Commissioner; provided, that the propriety of a termination for cause under subsection (a) of this section is certified in writing by an officer or authorized representative of the insurer or insurance producer terminating the relationship.

(2) In an action brought against a person that may have immunity under paragraph (1) of this section for making any statement required by this section or providing any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall prove actual malice with particularity.

(3) Paragraph (1) or (2) of this section shall not abrogate or modify any existing statutory or common law privileges or immunities.

(f)(1) Any documents, materials, or other information in the control or possession of the Department of Insurance, Securities, and Banking that is furnished by an insurer, an insurance producer, or an employee or agent thereof acting on behalf of the insurer or producer or obtained by the Commissioner in an investigation pursuant to this section shall be confidential and privileged, shall not be subject to subchapter II of Chapter 5 of Title 2, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in a private civil action; provided, that the Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties.

(2) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not testify in a private civil action concerning any confidential documents, materials, or information subject to paragraph (1) of this section.

(3) To assist in the performance of the Commissioner's duties under this chapter, the Commissioner:

(A) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to paragraph (1) of this subsection, with other state, federal, and international regulatory agencies, with the NAIC, its affiliates, or subsidiaries, or with state, federal, and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(B) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from

the NAIC, its affiliates, or subsidiaries or from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(C) May enter into agreements governing sharing and use of information consistent with this subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph (3) of this subsection.

(5) This chapter shall not prohibit the Commissioner from releasing final, adjudicated actions, including terminations for cause that are open to public inspection under subchapter II of Chapter 5 of Title 2 to a database or other clearinghouse service maintained by the NAIC, its affiliates, or subsidiaries.

(g) An insurer, the authorized representative of the insurer, or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with § 31-1131.12(d).

(Mar. 27, 2003, D.C. Law 14-264, § 15, 50 DCR 260; June 11, 2004, D.C. Law 15-166, § 4(g)(2), 51 DCR 2817.)

Effect of amendments. — D.C. Law 15-166, in par. (1) of subsec. (f), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(g)(2) of

Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1131.16. Reciprocity.

(a) Except for the requirements imposed by § 31-1131.08, the Commissioner shall waive any requirements for a nonresident license applicant with a valid license from his or her home state, if the applicant’s home state awards nonresident licenses to residents of the District on the same basis. The Commissioner may waive any requirements, except for those imposed by § 31-1131.08, for a nonresident license applicant with a valid license from the applicant’s home state if the applicant’s home state does not award nonresident licenses to residents of the District on the same basis.

(b) A nonresident insurance producer’s satisfaction of his or her home state’s continuing education requirements for licensed insurance producers shall constitute satisfaction of the District’s continuing education requirements if the nonresident producer’s home state recognizes the satisfaction of its continuing education requirements imposed upon insurance producers from the District on the same basis. The Commissioner may determine that a nonresident insurance producer’s satisfaction of his or her home state’s

continuing education requirements for licensed insurance producers constitutes satisfaction of the District's continuing education requirements if the nonresident producer's home state does not recognize the satisfaction of its continuing education requirements imposed upon insurance producers from the District on the same basis.

(c) A license issued to a nonresident of the District shall grant the same rights and privileges as a resident licensee.

(Mar. 27, 2003, D.C. Law 14-264, § 16, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(m), 55 DCR 3683.)

Effect of amendments. — D.C. Law 17-155, in subsec. (a), inserted: "The Commissioner may waive any requirements, except for those imposed by § 31-1131.08, for a nonresident license applicant with a valid license from the applicant's home state if the applicant's home state does not award nonresident licenses to residents of the District on the same basis."; in subsec. (b), inserted "The Commissioner may determine that a nonresident insurance producer's satisfaction of his or her home state's continuing education requirements for licensed insurance producers constitutes satisfaction of the District's continuing education require-

ments if the nonresident producer's home state does not recognize the satisfaction of its continuing education requirements imposed upon insurance producers from the District on the same basis."; and, in subsec. (c) deleted: "An applicant may qualify for a license under this chapter as a nonresident only if the applicant holds an equivalent license in his or her home state."

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.17. Reporting of actions.

(a) An insurance producer shall report to the Commissioner any administrative action taken against the insurance producer in another jurisdiction or by another governmental agency in the District within 30 days of the final disposition of the matter. The report shall include a copy of the order, consent to order, or other relevant legal documents.

(b) Within 30 days of the initial pretrial hearing date, an insurance producer shall report to the Commissioner any criminal prosecution of the insurance producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(Mar. 27, 2003, D.C. Law 14-264, § 17, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

§ 31-1131.18. Regulations.

The Commissioner may promulgate rules and regulations necessary or appropriate to implement the provisions of this chapter.

(Mar. 27, 2003, D.C. Law 14-264, § 18, 50 DCR 260; May 13, 2008, D.C. Law 17-155, § 2(n), 55 DCR 3683.)

Effect of amendments. — D.C. Law 17-155 substituted “necessary or appropriate” for “necessary”.

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

§ 31-1131.19. Transition.

(a) A license to do business as an insurance agent or broker in the District issued prior to March 27, 2003, shall be valid.

(b) This chapter shall not apply to any action, prosecution, or proceeding which is pending or may be initiated on the basis of facts and circumstances occurring before March 27, 2003.

(Mar. 27, 2003, D.C. Law 14-264, § 19, 50 DCR 260.)

Legislative history of Law 14-264. — For Law 14-264, see notes following § 31-1131.01.

CHAPTER 12. INSURANCE REGULATORY TRUST FUND.

Sec.	Sec.
31-1201. Definitions.	ganizations continuing obliga-
31-1202. Establishment of the Insurance Reg- ulatory Trust Fund; funding; uses; budget.	tions.
31-1203. Assessments.	31-1207. Records.
31-1204. Failure to pay share of assessment.	31-1208. Insurance Regulatory Trust Fund Bureau.
31-1205. Appeal from assessment.	31-1209. Annual audit of Insurance Regula- tory Trust Fund.
31-1206. Insurers and health maintenance or-	31-1210. Applicability.

§ 31-1201. Definitions.

For the purposes of this chapter, the term:

(1) “Assessable year” means the calendar year in which the direct gross receipts are received or derived from insurance business in the District of Columbia.

(1A) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(1A-i) “Continuing Care Retirement Community Regulatory and Supervision Trust Account” or “Account” means the account established within the Insurance Regulatory Trust Fund for the purpose of administering Chapter 1A of Title 44 [§ 44-151.01 et seq.], and for reasonable expenses incurred in promoting the continuing care retirement community industry in the District.

(1B) “Department of Insurance, Securities, and Banking” means the District of Columbia’s regulatory body which is responsible for administering the insurance laws and health maintenance organization laws of the District of Columbia.

(2) “Direct gross receipts” means all policy and membership fees and net premium receipts or consideration received in a calendar year on all insurance risks and annuity contracts originating in or from the District of Columbia. Direct gross receipts shall not include any policy or membership fees, net premium receipts, or consideration received from or paid by the District of Columbia’s Department of Health Care Finance.

(3) Repealed.

(4) “Insurer” means any person, firm, association, or corporation duly licensed in the District of Columbia pursuant to the applicable provisions of District insurance law as an insurer. In addition, Group Hospitalization and Medical Service Incorporated, shall be defined as an insurer.

(5) “Net premium receipts or consideration received” means gross premiums or consideration received less the sum of premiums received for reinsurance assumed and premiums or consideration returned on policies or contracts canceled or not taken.

(6) Repealed.

(Oct. 21, 1993, D.C. Law 10-40, § 2, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(a), 44 DCR 818; May 21, 1997, D.C. Law 11-268, § 10(y), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 36(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(h)(1), 51 DCR 2817; Apr. 5, 2005, D.C. Law 15-270, § 201(a), 52 DCR 799; Sept. 24, 2010, D.C. Law 18-223, § 5024, 57 DCR 6242.)

Prior Codifications. — 1981 Ed., § 35-2701.

Effect of amendments. — D.C. Law 15-166, in par. (1A), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”; and, in par. (1B), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

D.C. Law 15-270 added subsec. (1A-i).

D.C. Law 18-223, in par. (2), added the last sentence.

Temporary Amendment of Section. — Section 4 of D.C. Law 18-205, in par. (2), inserted “Direct gross receipts shall not include any policy or membership fees, net premium receipts, or consideration received from or paid by the Department of Health Care Finance.”

Section 7(b) of D.C. Law 18-205 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(h)(1) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) amendment of section, see § 4 of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18-390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5024 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 10-40. — Law 10-40, the “Insurance Regulatory Trust Fund Act of 1993,” was introduced in Council and assigned Bill No. 10-93, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-75 and transmitted to both Houses of Congress for its review. D.C. Law 10-40 became effective on October 21, 1993.

Legislative history of Law 11-235. — Law 11-235, the “Health Maintenance Organization Act of 1996,” was introduced in Council and assigned Bill No. 11-442, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and

December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-495 and transmitted to both Houses of Congress for its review. D.C. Law 11-235 became effective on April 9, 1997.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 15-270. — Law 15-270, the “Continuing Care Retirement Communities Act of 2004,” was introduced in Council and assigned Bill No. 15-94, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 9, 2004, and December 7, 2004, respectively. Signed by the Mayor on December 29, 2004, it was assigned Act No. 15-661 and transmitted to both Houses of Congress for its review. D.C. Law 15-270 became effective on April 5, 2005.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-40, the Insurance Regulatory Trust Fund Act of 1993, see Mayor’s Order 94-54, March 7, 1994 (41 DCR 1433).

Editor’s notes. — Mayor authorized to issue rules: Section 12 of D.C. Law 10-40 provided that the Mayor may, pursuant to subchapter I of Chapter 15 of Title 1 subchapter I of Chapter 5 of Title 2, 2001 Ed., issue rules to implement the provisions of this chapter.

§ 31-1202. Establishment of the Insurance Regulatory Trust Fund; funding; uses; budget.

(a) There is established within the General Fund of the District of Columbia a trust fund designated as the Insurance Regulatory Trust Fund, to which shall be credited all funds obtained pursuant to this chapter and Chapter 52A

of this title without regard to fiscal year limitation. All monies and interest earned on monies deposited in the Insurance Regulatory Trust Fund shall be credited to the Fund and used solely for the purpose of this chapter and Chapter 52A of this title. Insurers and health maintenance organizations will be assessed separately. The funds obtained from assessments on insurance companies and health maintenance organizations will not be commingled within the Trust Fund, and separate accounts will be maintained within the Trust Fund in order to properly allocate assessment revenue and expenditures to insurers and health maintenance organizations.

(b) Subject to the applicable laws relating to the appropriation of District funds, monies received and deposited in the Insurance Regulatory Trust Fund or a division thereof, shall be used to defray the expenses of the Department of Insurance, Securities, and Banking in the discharge of its administrative and regulatory duties as prescribed by law. These monies shall be deemed to include all administrative costs for regulating insurers and health maintenance organizations doing business in the District of Columbia, and no other assessments shall be charged for such purpose after the effective date of this chapter. The Mayor shall be responsible for the deposit and expenditure of these monies as provided by law.

(b-1)(1) There is established a separate account within the Insurance Regulatory Trust Fund for the purpose of funding the expenses of the Department of Insurance, Securities, and Banking in the discharge of all of its administrative, regulatory, and marketing functions under Chapter 39A of this title. All fees, fines, penalties, assessments, and other funds received by the Commissioner under Chapter 39A of this title and regulations promulgated thereunder, shall be deposited in, and credited to, the account. The Mayor shall be responsible for the deposit and expenditure of these monies as provided by law. At the end of each fiscal year, any funds in the account shall revert to the General Fund of the District of Columbia.

(2) Captive insurance companies conducting business in the District under Chapter 39A of this title shall be exempt from the assessments imposed on insurers and health maintenance organizations under § 31-1203.

(b-2)(1) There is established a separate account within the Insurance Regulatory Trust Fund for the purpose of administering Chapter 1A of Title 44, and for the reasonable expenses incurred in promoting the continuing care retirement community industry in the District. Continuing care retirement community providers conducting business in the District under Chapter 1A of Title 44, shall be exempt from the assessments imposed on insurers and health maintenance organizations under § 31-1203. All fees, fines, penalties, and assessments received by the Commissioner under the administration of Chapter 1A of Title 44, shall be deposited in, and credited to, the Account.

(2) Subject to the applicable law relating to the appropriation of District funds, all funds in the Continuing Care Retirement Community Regulatory and Supervision Trust Fund Account shall be disbursed only upon the approval of the Commissioner.

(3) At the end of each fiscal year, any funds in the Continuing Care Retirement Community Regulatory and Supervision Fund Account shall be applied against the budget for the ensuing year.

(c)(1) The Mayor shall submit to the Council, as a part of the annual budget, a requested appropriation for expenditures from the Insurance Regulatory Trust Fund. Any monies received but not expended in a given fiscal year shall be retained by the Fund and applied against the budget for the ensuing year, and the assessments for that year reduced accordingly.

(2) The Mayor's request shall be based on an estimated projection of the expenditures necessary to perform the administrative and regulatory functions of the Insurance Administration. This estimate shall include, but not be limited to, expenditures for salaries, fringe benefits, overhead charges, travel, training, supplies, technical, professional, and any and all other services necessary to discharge the duties and responsibilities of administering the insurance laws of the District of Columbia.

(d) The Council of the District of Columbia shall approve and establish the budget of the Insurance Regulatory Trust Fund in the same manner and at the same level of detail as approved and established for departments and agencies under the administrative control of the Mayor as provided in § 1-204.04(f).

(Oct. 21, 1993, D.C. Law 10-40, § 3, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, §§ 24(b)-(d), 44 DCR 818; June 11, 2004, D.C. Law 15-166, § 4(h)(2), 51 DCR 2817; Mar. 17, 2005, D.C. Law 15-262, § 25, 52 DCR 1205; Apr. 5, 2005, D.C. Law 15-270, § 201(b), 52 DCR 799; Oct. 20, 2005, D.C. Law 16-33, § 2202, 52 DCR 7503; Apr. 7, 2006, D.C. Law 16-91, § 102(c), 52 DCR 10637; Mar. 2, 2007, D.C. Law 16-191, §§ 44(c), 52, 54(e), 53 DCR 6794.)

Cross references. — Establishment of health maintenance organizations, deposit of filing fee, see § 31-3402.

Prior Codifications. — 1981 Ed., § 35-2702.

Effect of amendments. — D.C. Law 15-166, in subsec. (b), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

D.C. Law 15-262 added subsec. (b-1).

D.C. Law 15-270 added subsec. (b-2).

D.C. Law 16-33, in subsec. (a), substituted "this chapter and Chapter 52A of this title," for "this chapter".

D.C. Law 16-91, in subsec. (b-1)(1), deleted "Except as otherwise provided in § 31-3931.12(g)," preceding "All fees, fines".

D.C. Law 16-191, in subssecs. (b), (b-1), and (b-2), validated previously made technical corrections.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3 of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(h)(2) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) amendment of section, see § 3 of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) amendment of section, see § 3 of Captive Insurance Company Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) amendment of section, see § 25 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

For temporary (90 day) amendment of section, see § 2202 of Fiscal Year 2006 Budget Support Emergency Act of 2005 (D.C. Act 16-168, July 26, 2005, 52 DCR 7667).

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 15-262. — Law 15-262, the "Captive Insurance Company Act of 2004", was introduced in Council and assigned

Bill No. 15-834, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 5, 2004, and November 9, 2004, respectively. Signed by the Mayor on November 30, 2004, it was assigned Act No. 15-638 and transmitted to both Houses of Congress for its review. D.C. Law 15-262 became effective on March 17, 2005.

Legislative history of Law 15-270. — For Law 15-270, see notes following § 31-1201.

Legislative history of Law 16-33. — Law 16-33, the “Fiscal Year 2006 Budget Support Act of 2005”, was introduced in Council and assigned Bill No. 16-200 which was referred to the Committee of the Whole. The Bill was

adopted on first and second readings on May 10, 2005, and June 21, 2005, respectively. Signed by the Mayor on July 26, 2005, it was assigned Act No. 16-166 and transmitted to both Houses of Congress for its review. D.C. Law 16-33 became effective on October 20, 2005.

Legislative history of Law 16-91. — For Law 16-91, see notes following § 31-3931.02.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Short title. — Short title of subtitle L of title II of Law 16-33: Section 2201 of D.C. Law 16-33 provided that subtitle L of title II of the act may be cited as the Insurance Regulatory Trust Fund Enhancement Act of 2005.

§ 31-1203. Assessments.

(a) The Mayor shall assess annually each insurer and health maintenance organization doing business in the District an amount based on a percentage of its direct gross receipts for the preceding year, provided that each insurer and health maintenance organization shall be subject to a minimum annual assessment of no less than \$1000. The Mayor shall establish in each assessable year the assessment rate, not to exceed $\frac{3}{10}$ of 1% of the direct gross receipts. In no event shall the amount assessed exceed the amount budgeted by the Council.

(b) The Mayor shall compute the assessment for each insurer and health maintenance organization and send the insurer and health maintenance organization this information in a “Notice of Assessment”. Each insurer and health maintenance organization shall pay to the Mayor the amount stated in the Notice of Assessment within 30 days of the mailing date of the Notice of Assessment.

(c) The annual billing cycle for the assessment established by this section shall be the fiscal year of the District of Columbia.

(Oct. 21, 1993, D.C. Law 10-40, § 4, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(e), 44 DCR 818.)

Section references. — This section is referred to in §§ 31-1202 and 31-1204.

Prior Codifications. — 1981 Ed., § 35-2703.

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see His-

torical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

§ 31-1204. Failure to pay share of assessment.

(a) Any insurer or health maintenance organization that fails to pay an assessment on or before the date set forth in § 31-1203 shall be subject to a penalty imposed by the Mayor, which shall be 10% of the assessment plus interest at one-half of 1% per month for the period between the due date and the date of full payment. If a payment is made in an amount later found to be in error, the Mayor shall do one of the following:

(1) If an additional amount is due, notify the insurer of the additional amount which shall be due within 15 days of the date of mailing of the notice; or

(2) If overpayment is made, order a refund.

(b) If an insurer or health maintenance organization fails to pay the amount of the assessment in a timely manner, the Mayor shall send the insurer or health maintenance organization a notice of deficiency, and 10 days after serving the deficiency notice may take whatever action, in the Mayor's discretion, the Mayor deems appropriate, including suspending or revoking the insurer's or health maintenance organization's certificate of authority or license to transact business, or any other appropriate action or sanction authorized under the insurance laws for failure to comply with District laws, including referring the matter to the Corporation Counsel for legal action to collect the assessment.

(c) In the event that any insurer or health maintenance organization fails, by reason of insolvency, impairment of capital and surplus, or other reason approved by the Mayor, to pay its assessment in full, the unpaid amounts shall be assessed against the remaining insurers or health maintenance organizations respectively, on a proportionate basis in comparison to their direct gross receipts. Any insurer or health maintenance organization paying this additional assessment shall have a claim against the defaulting insurer or health maintenance organization for the amount paid.

(Oct. 21, 1993, D.C. Law 10-40, § 5, 40 DCR 6009; May 16, 1995, D.C. Law 10-255, § 28, 41 DCR 5193; Apr. 9, 1997, D.C. Law 11-235, §§ 24(f)-(h), 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 36(b), 45 DCR 745.)

Section references. — This section is referred to in § 31-1205.

Prior Codifications. — 1981 Ed., § 35-2704.

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 10-255. — Law 10-255, the "Technical Amendments Act of 1994," was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994,

and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-1201.

§ 31-1205. Appeal from assessment.

Any insurer or health maintenance organization aggrieved by an assessment may appeal under procedures established in § 101 of Title 26 of the District of Columbia Municipal Regulations (26 DCMR 101), or as otherwise may be provided by the Mayor. If an appellant fails to pay the assessment when due, the appellant shall be liable for any amounts correctly assessed and any penalties and interest due thereon. The appellant shall pay any amounts owed within 10 days of a final decision and the Mayor may take whatever action is appropriate under this chapter, including action under § 31-1204, or

any other laws regulating the insurance industry to effect collection. In addition, the Insurance Regulatory Trust Fund Bureau may appeal to the Mayor the entire annual assessment or a specific expenditure or category of expenditure, in accordance with the procedures established in 26 DCMR 101, if it believes the assessment is not in accordance with this chapter or applicable laws.

(Oct. 21, 1993, D.C. Law 10-40, § 6, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(i), 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-2705.

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

§ 31-1206. Insurers and health maintenance organizations continuing obligations.

Any insurer or health maintenance organization whose license has been revoked, cancelled, terminated, or surrendered shall continue to be bound by the obligations of this chapter including payment of all assessments, regardless of whether the insurer or health maintenance organization continues to do business in the District of Columbia.

(Oct. 21, 1993, D.C. Law 10-40, § 7, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(j), 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-2706.

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

§ 31-1207. Records.

The Mayor shall, at all reasonable times, make books, records, and files available to insurance company representatives for the purpose of examining any matter coming within the scope of the chapter and the insurance laws of the District of Columbia.

(Oct. 21, 1993, D.C. Law 10-40, § 8, 40 DCR 6009.)

Prior Codifications. — 1981 Ed., § 35-2707.

Legislative history of Law 10-40. — For

legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

§ 31-1208. Insurance Regulatory Trust Fund Bureau.

All insurers and health maintenance organizations subject to assessments in accordance with this chapter shall be members of an Insurance Regulatory Trust Bureau, organized and maintained by such insurers and health main-

tenance organizations at their own expense, for the purpose of advising the Commissioner of the Department of Insurance, Securities, and Banking annually as to the need for the proposed assessments, the fairness of the proposed assessments, and any other matters with respect to the administration of the Insurance Regulatory Trust Fund. The Commissioner shall submit to the Insurance Regulatory Trust Fund Bureau annually, in advance of the Mayor's budget submission to the Council, a detailed budget showing how the proposed assessments are to be expended.

(Oct. 21, 1993, D.C. Law 10-40, § 9, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(k), 44 DCR 818; May 21, 1997, D.C. Law 11-268, § 10(y), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(h)(3), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-2708.

Effect of amendments. — D.C. Law 15-166 substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(h)(3) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see His-

torical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1202.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1209. Annual audit of Insurance Regulatory Trust Fund.

Upon a vote of the Insurance Regulatory Trust Fund Bureau taken in accordance with its bylaws, the Insurance Regulatory Trust Fund Bureau, at its own expense, may annually arrange for an independent audit of the expenditures made in any fiscal year by the Insurance Regulatory Trust Fund. The Commissioner, the Department of Insurance, Securities, and Banking, and all other elements of the Government of the District of Columbia shall cooperate with such an audit and shall make available all documents and records reasonably necessary to the conduct of the audit.

(Oct. 21, 1993, D.C. Law 10-40, § 10, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(l), 44 DCR 818; May 21, 1997, D.C. Law 11-268, § 10(y), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 36(c), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(h)(4), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-2709.

Effect of amendments. — D.C. Law 15-166 substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(h)(4) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-1201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-1201.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1210. Applicability.

(a) All health maintenance organizations, life, health, property, marine, title, casualty, fidelity, surety, insurance companies and fraternal benefit associations now or hereafter incorporated or formed in the District of Columbia or authorized to do business in the District of Columbia, shall be subject to this chapter. This chapter shall also apply to Group Hospitalization and Medical Service, Incorporated, and any other company or organization whether for profit or nonprofit subject to regulation by the Insurance Administration.

(b) The provisions of this chapter shall not apply until October 1, 1993.

(Oct. 21, 1993, D.C. Law 10-40, § 11, 40 DCR 6009; Apr. 9, 1997, D.C. Law 11-235, § 24(m), 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-2710.

Legislative history of Law 10-40. — For legislative history of D.C. Law 10-40, see Historical and Statutory Notes following § 31-1201.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-1201.

CHAPTER 13. INSURERS REHABILITATION AND LIQUIDATION PROCEDURES.

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§ 31-1301. Definitions.

For the purposes of this chapter, the term:

(1) "Ancillary state" means any state other than a domiciliary state.

(1A) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(2) "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(3) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer, and any summary proceeding under § 31-1308.

(4) "District" means the District of Columbia.

(5) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(A) The issuance or delivery of contracts of insurance to persons resident in the District;

(B) The solicitation of applications for the contracts, or other negotiations preliminary to the execution of the contracts;

(C) The collection of premiums, membership fees, assessments, or other consideration for the contracts;

(D) The transaction of matters subsequent to execution of the contracts and arising out of them; or

(E) Operating under a license or certificate of authority, as an insurer, issued by the District.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(7) "Fair consideration" is given for property or obligation:

(A) When, in exchange for the property or obligation, as a fair equivalent therefor and in good faith, property is conveyed, services are rendered, an obligation is incurred, or an antecedent debt is satisfied; or

(B) When the property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(8) "Foreign country" means any other jurisdiction not in any state.

(9) "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(10) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, the term "general assets" includes all the property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(11) "Guaranty association" means the District of Columbia Property and Casualty Insurance Guaranty Association, and any other similar entity now or hereafter created by the Council of the District of Columbia for the payment of claims of insolvent insurers. The term "foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(12) "Insolvency" or "insolvent" means:

(A) For an insurer issuing only assessable fire insurance policies:

(i) The inability to pay any obligation within 30 days after it becomes payable; or

(ii) If an assessment be made within 30 days after the date, the inability to pay the obligation 30 days following the date specified in the first assessment notice issued after the date of loss;

(B) For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(i) Any capital and surplus required by law for its organization; or
(ii) The total par or stated value of its authorized and issue capital stock;

(C) As to any insurer licensed to do business in the District as of October 15, 1993, which does not meet the standard established under subparagraph (B) of this paragraph for a period not to exceed 3 years from October 15, 1993, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the Commissioner under provisions of the insurance law; and

(D) For purposes of this paragraph, the term "liabilities" shall include, but not be limited to, capital, surplus, or other reserves required by statute or by insurance administration general regulations, or specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto.

(13) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance superintendent or commissioner.

(14) "Person" means corporations, partnerships, associations, trusts, and individual natural persons.

(15) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(16) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

(17) "Reciprocal state" means any state other than the District in which in substance and effect §§ 31-1316(a), 31-1350, 31-1351, and 31-1353 through 31-1355 are in force, and in which provisions are in force requiring that the Commissioner or equivalent official be the receiver of a delinquent insurer, and in which fraudulent conveyances and preferential transfers by a delinquent insurer may be avoided.

(18) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term "secured claim" also includes claims which have become liens upon specific assets by reason of judicial process.

(19) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(20) "State" means any state, district, or territory of the United States and the Panama Canal Zone.

(21) Repealed.

(22) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

(Oct. 15, 1993, D.C. Law 10-35, § 2, 40 DCR 5773; May 16, 1995, D.C. Law 10-255, § 27(a), 41 DCR 5193; May 21, 1997, D.C. Law 11-268, § 10(z)(1), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 37(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(i)(1), 51)

Section references. — This section is referred to in § 31-755.

Prior Codifications. — 1981 Ed., § 35-2801.

Effect of amendments. — D.C. Law 15-166, in par. (1A), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(i)(1) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-35. — Law 10-35, the “Insurers Rehabilitation and Liquidation Act of 1993,” was introduced in Council and assigned Bill No. 10-123, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-68 and transmitted to both Houses of Congress for its review. D.C. Law 10-35 became effective on October 15, 1993.

Legislative history of Law 10-255. — Law 10-255, the “Technical Amendments Act of 1994,” was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted

on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1302. Applicability.

The proceedings authorized by this chapter may be applied to:

- (1) All insurers who are doing, or have done, an insurance business in the District, and against whom claims arising from that business may exist now or in the future;
- (2) All insurers who purport to do an insurance business in the District;
- (3) All insurers who have insureds resident in the District;
- (4) All other persons organized or in the process of organizing with the intent to do an insurance business in the District;
- (5) All title insurance companies subject to the laws of the District;
- (6) All prepaid health care delivery plans;
- (7) All nonprofit service plans and all fraternal benefit societies and beneficial societies; and
- (8) All insurers making contracts of fidelity or surety contracts or other negotiations preliminary to the executions of the contracts.

(Oct. 15, 1993, D.C. Law 10-35, § 3, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2802. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For 1301.

§ 31-1303. Jurisdiction and venue.

(a) No delinquency proceeding shall be commenced under this chapter by anyone other than the Commissioner of the Department of Insurance, Securities, and Banking and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(b) No court of the District of Columbia shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to these proceedings other than in accordance with this chapter.

(c) In addition to other grounds for jurisdiction provided by law of the District, the Superior Court of the District of Columbia has jurisdiction over a person served pursuant to the Superior Court Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in the District:

(1) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(2) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract;

(3) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(4) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) If the person served is obligated to the insurer, in any way whatsoever, in any action on or incident to the obligation.

(d) If the court, on motion of any party, finds that any action should as a matter of substantial justice be tried in a forum outside the District, the court may enter an appropriate order to stay further proceedings on the action in the District.

(e) All action authorized in this section shall be brought in the Superior Court of the District of Columbia.

(Oct. 15, 1993, D.C. Law 10-35, § 4, 40 DCR 5773; May 21, 1997, D.C. Law

11-268, § 10(z)(2), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(i)(2), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-2803.

Effect of amendments. — D.C. Law 15-166, in subsec. (a), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(i)(2) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1304. Injunctions and orders.

(a) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, restraining orders, preliminary and permanent injunctions, and other orders deemed necessary and proper to prevent:

- (1) The transaction of further business;
 - (2) The transfer of property;
 - (3) Interference with the receiver or with a proceeding under this chapter;
 - (4) Waste of the insurer’s assets;
 - (5) Dissipation and transfer of bank accounts;
 - (6) The institution or further prosecution of any actions or proceedings;
 - (7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders;
 - (8) The levying of execution against the insurer, its assets, or its policyholders;
 - (9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;
 - (10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or
 - (11) Any other threatened or contemplated action that might lessen the value of the insurer’s assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.
- (b) The receiver may apply to any court outside of the jurisdiction for the relief described in subsection (a) of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 5, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2804.

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1305. Cooperation of officers, owners, and employees.

(a) Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment

of the insurer's affairs, shall cooperate with the Commissioner in any proceeding under this chapter or any investigation preliminary to the proceeding. For the purposes of this section, the term "person" shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. The term "to cooperate" shall include, but shall not be limited to, the following:

(1) To reply promptly in writing to any inquiry from the Commissioner requesting such a reply; and

(2) To make available to the Commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody, or control.

(b) No person shall obstruct or interfere with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation, other delinquency proceedings, or other orders.

(d) Any person included within subsection (a) of this section who fails to cooperate with the Commissioner, or any person who obstructs or interferes with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order of the Commissioner issued validly under this chapter may:

(1) Be sentenced to pay a fine not exceeding \$10,000 or imprisonment for a term of not more than 1 year, or both; or

(2) After a hearing, be subject to the imposition by the Commissioner of a civil penalty not to exceed \$10,000 and be subject further to the revocation or suspension of any insurance license issued by the Commissioner.

(Oct. 15, 1993, D.C. Law 10-35, § 6, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1321.

Prior Codifications. — 1981 Ed., § 35-2805.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see His-

torical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1306. Continuation of delinquency proceedings.

Every proceeding commenced under §§ 31-2502.05 through 31-2502.07 [repealed], and §§ 31-4319 through 31-4321 [repealed], shall be deemed to have commenced under this chapter for the purpose of continuing the proceeding, except that in the discretion of the Commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this chapter not been enacted.

(Oct. 15, 1993, D.C. Law 10-35, § 7, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2806.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

References in text. — “Sections 31-4319 through 31-4321”, referred to in this section, were repealed by D.C. Law 10-35, § 59(a), 40 DCR 5773, effective October 15, 1993.

“Sections 31-2502.05 through 31-2502.07”, referred to in this section, were repealed by D.C. Law 10-35, § 59(b), 40 DCR 5773, effective October 15, 1993.

§ 31-1307. Condition on release from delinquency proceedings; conditions on operations during proceedings.

No insurer that is subject to any delinquency proceedings, whether formal or informal (administrative or judicial), shall:

(1) Be released from the proceeding, unless the proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(2) Be permitted to solicit or accept new business, or request or accept the restoration of any suspended or revoked license or certificate of authority;

(3) Be returned to the control of its shareholders or private management; or

(4) Have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer’s contractual obligations by all guaranty associations, along with all expenses and interest on all payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

(Oct. 15, 1993, D.C. Law 10-35, § 8, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2807.

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1308. Temporary seizure order.

(a) The Commissioner may file in the Superior Court of the District of Columbia a petition alleging, with respect to a domestic insurer, that there exists grounds that would justify a court order for a formal delinquency proceeding against an insurer under this chapter, and that the interests of policyholders, creditors, or the public will be endangered by delay in the Commissioner’s determination of the financial condition of the insurer.

(b) Upon a filing under subsection (a) of this section, the court may issue, ex parte and without a hearing, the requested order which shall direct the Commissioner to take possession and control of all or part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoins the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the Commissioner.

(c) The court shall specify in the order its duration, which shall be the time the court deems necessary for the Commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold hearings it deems desirable after notice it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the Commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter shall ipso facto vacate the seizure order.

(d) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(e) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of the order for a hearing and review of the order. The court shall hold such a hearing and review not more than 15 days after the request. A hearing under this subsection may be held privately in chambers and it shall be if the insurer proceeded against so requests.

(f) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

(Oct. 15, 1993, D.C. Law 10-35, § 9, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Cross references. — Ancillary proceedings, domiciliary state of any foreign or alien insurer having property located in the District, see § 31-1352.

Section references. — This section is referred to in §§ 31-1301 and 31-1309.

Prior Codifications. — 1981 Ed., § 35-2808.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1309. Confidentiality of records.

In all proceedings and judicial reviews under § 31-1308, all records of the insurer, other documents, all Department of Insurance, Securities, and Banking files, court records, and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance, unless and until the Superior Court of the District of Columbia, after hearing arguments from the parties in chambers, shall order otherwise, or unless the insurer requests that the matter be made public. Until such a court order, all papers filed with the clerk of the Superior Court of the District of Columbia shall be held in a confidential file. The Commissioner may share documents, materials, or other information in the possession or control of the Department of Insurance, Securities, and Banking pertaining to an insurer that is the subject of a proceeding under this chapter with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners, including its affiliates and

subsidiaries; and with state, federal, and international law enforcement authorities; provided, that the recipient agrees, and has the legal authority, to maintain the confidentiality of the documents, material, or other information. No waiver of an applicable privilege or claim of confidentiality shall occur as a result of disclosure to the Commissioner or of sharing documents, materials, or other information under this section. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(Oct. 15, 1993, D.C. Law 10-35, § 10, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(1), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-191, § 2(a), 47 DCR 7311; June 11, 2004, D.C. Law 15-166, § 4(i)(3), 51 DCR 2817.)

Cross references. — Ancillary proceedings, domiciliary state of any foreign or alien insurer having property located in the District, see § 31-1352.

Prior Codifications. — 1981 Ed., § 35-2809.

Effect of amendments. — D.C. Law 13-191 added the concluding three sentences to the section.

D.C. Law 15-166 substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance Securities” and substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(i)(3) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see His-

torical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 13-191. — Law 13-191, the “Insurer Confidentiality and Information Sharing Amendment Act of 2000,” was introduced in Council and assigned Bill No. 13-706, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-419 and transmitted to both Houses of Congress for its review. D.C. Law 13-191 became effective on October 21, 2000.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1309.01. Duty to provide information to other insurance regulators and guaranty associations.

The domiciliary receiver shall provide information to other state insurance regulators and guaranty associations, including reports and analyses of financial condition and the status of development of a plan of rehabilitation. The domiciliary receiver shall also permit a state insurance regulator or guaranty association to obtain a listing of policyholders and certificate holders residing in the requestor’s state, including current addresses and summary policy information; provided, that (1) the regulator or guaranty association agrees, and has the legal authority, to maintain the confidentiality of the records, and (2) records will be used only for regulatory or guaranty association purposes. Access to financial records shall be at least equivalent to that to which a state insurance regulator was entitled before the commencement of a formal delinquency proceeding. Access to records may be limited to normal business hours. If the domiciliary receiver believes that certain information is sensitive and disclosure might cause a diminution in recovery, the receiver may apply for a protective order imposing additional restrictions on access. No

waiver of an applicable privilege shall occur as a result of disclosure to the Commissioner or receiver or of sharing documents, materials, or other information under this section. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(Oct. 15, 1993, D.C. Law 10-35, § 10a, as added Oct. 21, 2000, D.C. Law 13-191, § 2(b), 47 DCR 7311.)

Legislative history of Law 13-191. — For Law 13-191, see notes following § 31-1309.

§ 31-1310. Grounds for rehabilitation.

The Commissioner may apply by petition to the Superior Court of the District of Columbia for an order authorizing him or her to rehabilitate a domestic insurer or an alien insurer domiciled in the District based on any one or more of the following grounds:

(1) The insurer is in such a condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the Commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy in any way that affects the insurer's business.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the Commissioner concerning its affairs, whether in the District or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate its relationship with that person, or to prevent that person from influencing the insurer's management.

(6) After demand by the Commissioner under this chapter, or any law authorizing the Commissioner to examine the operations of an insurer, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(7) Without first obtaining the written consent of the Commissioner, the

insurer has transferred, or attempted to transfer, in a manner contrary to Chapter 7 of this title, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property other than as authorized under the insurance laws of the District, and the appointment has been made or is imminent, and the appointment would deprive the courts of the District of Columbia of jurisdiction or might prejudice the orderly delinquency proceedings under this chapter.

(9) The insurer, within the previous 4 years, willfully violated its charter or articles of incorporation, its bylaws, any insurance law of the District, or any valid order of the Commissioner.

(10) The insurer has failed to pay, within 60 days after due date, any obligation to any state or any subdivision or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter, except that the nonpayment shall not be a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the Commissioner or in court, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law, and, after written demand by the Commissioner, has failed to give an adequate explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in the insurance laws of the District, request or consent to rehabilitation under this chapter.

(Oct. 15, 1993, D.C. Law 10-35, § 11, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Cross references. — Rehabilitation, liquidation, or conservation of health maintenance organizations, see § 31-3420.

Section references. — This section is referred to in §§ 31-1314, 31-1315, 31-1348, and 31-1349.

Prior Codifications. — 1981 Ed., § 35-2810.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1311. Rehabilitation orders.

(a) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in the District, shall appoint the Commissioner and his or her successors in office the rehabilitator, and shall direct the rehabilitator

forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the Superior Court of the District of Columbia shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(b) Any order issued under this section shall require accountings to the court by the rehabilitator. Accountings shall be at intervals the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under § 31-1312(e) will be prepared by the rehabilitator and the timetable for doing so.

(c) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless the revocation or cancellation is done by the rehabilitator pursuant to § 31-1312.

(Oct. 15, 1993, D.C. Law 10-35, § 12, 40 DCR 5773; May 16, 1995, D.C. Law 10-255, § 27(b), 41 DCR 5193; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1335.

Prior Codifications. — 1981 Ed., § 35-2811.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-255. — For legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1312. Powers and duties of the rehabilitator.

(a) The Commissioner as rehabilitator may appoint 1 or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the Commissioner may employ any counsel, clerks, and assistants deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the Commissioner, with the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the Commissioner. The Commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should that committee be deemed necessary. The advisory committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in rehabilitation proceedings conducted under this chapter.

(b) In the event that the property of the insurer does not contain sufficient

cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the Department of Insurance, Securities, and Banking. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the Department of Insurance, Securities, and Banking out of the first available money of the insurer.

(c) The rehabilitator may take such action as deemed necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(d) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he or she may pursue all appropriate legal remedies on behalf of the insurer.

(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect the changes. Upon application of the rehabilitator for approval of the plan, and after any notice and hearings the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such a period and to such an extent as may be necessary.

(f) The rehabilitator shall have the power under §§ 31-1324 and 31-1325 to avoid fraudulent transfers.

(Oct. 15, 1993, D.C. Law 10-35, § 13, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(i)(4), 51 DCR 2817.)

Section references. — This section is referred to in §§ 31-1311 and 31-1314.

Prior Codifications. — 1981 Ed., § 35-2812.

Effect of amendments. — D.C. Law 15-166, in subsec. (b), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities” both times it appears.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(i)(4) of Consolidation of Financial Services Emergency

Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1313. Actions by and against the rehabilitator.

(a) Any court in the District before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and any additional time necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take any action respecting the pending litigation deemed necessary in the interests of, justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside the District and shall petition the court having jurisdiction over that litigation for a stay whenever necessary to protect the estate of the insurer.

(b) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within 1 year or any other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered.

(c) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if the association is or may become liable to act as a result of the rehabilitation.

(Oct. 15, 1993, D.C. Law 10-35, § 14, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2813. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For 1301.

§ 31-1314. Termination of rehabilitation.

(a) Whenever the Commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the Commissioner may petition the Superior Court of the District of Columbia for an order of liquidation. A petition under this subsection shall have the same effect as a petition under § 31-1315. The Superior Court of the District of Columbia shall permit the directors of the insurer to take any action reasonably necessary to defend against the petition and may order payment from the estate of the insurer of the costs and other expenses of defense as justice may require.

(b) The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of 6

months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under § 31-1312(e), the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(c) The rehabilitator may at any time petition the Superior Court of the District of Columbia for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of the costs and other expenses of the petition as justice may require. If the Superior Court of the District of Columbia finds that rehabilitation has been accomplished and that grounds for rehabilitation under § 31-1310 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The Superior Court of the District of Columbia may also make that finding and issue that order at any time upon its own motion.

(Oct. 15, 1993, D.C. Law 10-35, § 15, 40 DCR 5773; May 16, 1995, D.C. Law 10-255, § 27(c), 41 DCR 5193; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2814.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-255. — For

legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1315. Grounds for liquidation.

The Commissioner may petition the Superior Court of the District of Columbia for an order directing him or her to liquidate a domestic insurer or an alien insurer domiciled in the District on the basis:

(1) Of any ground for an order of rehabilitation as specified in § 31-1310, whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) That the insurer is insolvent; or

(3) That the insurer is in such a condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

(Oct. 15, 1993, D.C. Law 10-35, § 16, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Cross references. — Rehabilitation, liquidation, or conservation of health maintenance organizations, see § 31-3420.

Section references. — This section is referred to in §§ 31-1314 and 31-1349.

Prior Codifications. — 1981 Ed., § 35-2815.

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1316. Liquidation orders.

(a) An order to liquidate the business of a domestic insurer shall appoint the Commissioner and his or her successors in office liquidator and shall direct the liquidator to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the Clerk of the Superior Court of the District of Columbia, or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(b) Upon issuance of the order, the rights and liabilities of any insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in §§ 31-1317 and 31-1335.

(c) An order to liquidate the business of an alien insurer domiciled in the District shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(d) At the time of petitioning for an order of liquidation, or at any time thereafter, the Commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of insolvency. After providing notice and hearing it deems proper, the court may make the declaration.

(e) Any order issued under this section shall require financial reports to the court by the liquidator. Financial reports shall include, at a minimum, the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within 1 year of the liquidation order and at least annually thereafter.

(f)(1) Within 5 days of October 15, 1993, or, if later, within 5 days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the Commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such a plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the defendant company's financial condition will not, in the judgment of the Commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the Commissioner finds to be fair and equitable considering the relative circumstances of the policyholders and claimants. The court shall

examine the plan submitted by the Commissioner, and, if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the Commissioner or any of his deputies, agents, clerks, assistants, or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(2) The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

(3) Any plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, so that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, in the event an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses in connection therewith relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest, or unless an arrangement for repayment has been made with the consent of all applicable guaranty associations.

(Oct. 15, 1993, D.C. Law 10-35, § 17, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Cross references. — Property and liability insurance guaranty association, insolvent insurer defined, see § 31-5501.

Section references. — This section is referred to in §§ 31-1301, 31-1329, 31-1335, and 31-1317.

Prior Codifications. — 1981 Ed., § 35-2816.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1317. Continuance of coverage.

(a) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

- (1) A period of 30 days from the date of entry of the liquidation orders;
- (2) The expiration of the policy coverage;
- (3) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;
- (4) The liquidator has effected a transfer of the policy obligation pursuant to § 31-1319(a)(9); or
- (5) The date proposed by the liquidator and approved by the court to cancel coverage.

(b) An order of liquidation under § 31-1316 shall terminate coverages at the time specified in subsection (a) of this section for purposes of any other statute.

(c) Policies of life or health insurance or annuities shall continue in force for

such a period and under the terms provided for by any applicable guaranty association or foreign guaranty association.

(d) Policies of life or health insurance or annuities or any period or coverage of any policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (a) and (b) of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 18, 40 DCR 5773; May 16, 1995, D.C. Law 10-255, § 27(d), 41 DCR 5193; Apr. 18, 1996, D.C. Law 11-110, § 40, 43 DCR 530.)

Section references. — This section is referred to in § 31-1316.

Prior Codifications. — 1981 Ed., § 35-2817.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-255. — For legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-110. — Law 11-110, the “Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

§ 31-1318. Dissolution of insurer.

The Commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in the District at the time he or she applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the Commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent, but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

(Oct. 15, 1993, D.C. Law 10-35, § 19, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1319.

Prior Codifications. — 1981 Ed., § 35-2818.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-

1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1319. Powers of liquidator.

(a) The liquidator shall have the power:

(1) To appoint a special deputy or deputies to act for him or her under this chapter, and to determine his or her reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator;

(2) To hire employees, agents, legal counsel, actuaries, accountants,

appraisers, consultants, and other personnel he or she deems necessary to assist in the liquidation;

(3) To appoint, with the approval of the court, an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should such a committee be deemed necessary. The committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in liquidation proceedings conducted under this chapter;

(4) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court;

(5) To pay reasonable compensation to persons appointed, and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs incurred out of any appropriation for the maintenance of the Department of Insurance, Securities, and Banking. Any amounts advanced for expenses of administration shall be repaid to the Commissioner for the use of the Department of Insurance, Securities, and Banking out of the first available monies of the insurer;

(6) To hold hearings, subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, and compel any person to subscribe to his or her testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records, or other documents which the liquidator deems relevant to the inquiry;

(7) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(8) To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(A) To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against the debts;

(B) To do any other acts necessary or expedient to collect, conserve, or protect assets or property of the insurer, including the power to sell, compound, compromise, or assign debts for purposes of collection upon terms and conditions as he or she deems best; and

(C) To pursue any creditor's remedies available to enforce his or her claims;

(9) To conduct public and private sales of the property of the insurer;

(10) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under § 31-1340;

(11) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the insurer at its market value or upon terms and conditions that are fair and reasonable. The

liquidator shall also have power to execute, acknowledge, and deliver all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(12) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution;

(13) To enter into any contracts necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party;

(14) To continue to prosecute and to institute in the name of the insurer, or in his or her own name, any and all suits and other legal proceedings, in the District or elsewhere, and to abandon the prosecution of claims he or she deems unprofitable to pursue further. If the insurer is dissolved under § 31-1318, the liquidator shall have the power to apply to any court in the District or elsewhere for leave to substitute himself or herself for the insurer as plaintiff;

(15) To prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person;

(16) To remove any or all records and property of the insurer to the offices of the Commissioner or to any other place convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have reasonable access to the records of the insurer necessary for them to carry out their statutory obligations;

(17) To deposit in 1 or more banks in the District the sums required for meeting current administration expenses and dividend distributions;

(18) To invest all sums not currently needed, subject to the same standards that would apply if those sums were invested by the insurer, unless the court orders otherwise;

(19) To file any necessary documents for record in the office of any recorder of deeds or record office in the District or elsewhere where property of the insurer is located;

(20) To assert all defenses available to the insurer against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such an obligation and may defend only in the absence of a defense by the guaranty associations;

(21) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included within §§ 31-1324 through 31-1326;

(22) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered;

(23) To enter into agreements with any receiver or superintendent or commissioner of insurance of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states; and

(24) To exercise all powers now held or hereafter conferred upon receivers by the laws of the District not inconsistent with the provisions of this chapter.

(b)(1) If a company placed in liquidation issued liability policies on a claims-made basis, which provided an option to purchase an extended period to report claims, the liquidator may make available to holders of the policies, for a charge, an extended period to report claims as stated herein. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or 18 months from the order of liquidation.

(2) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such an extended period within 60 days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. The offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within 90 days after the order of liquidation. No commissions, premium taxes, assessments, or other fees shall be due on the charge pertaining to the extended period to report claims.

(c) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him or her, nor shall it exclude in any manner his or her right to do other acts not specifically enumerated or otherwise provided for, necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(d) Notwithstanding the powers of the liquidator stated in subsections (a) and (b) of this section, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

(Oct. 15, 1993, D.C. Law 10-35, § 20, 40 DCR 5773; May 16, 1995, D.C. Law 10-255, § 27(e), 41 DCR 5193; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 37(b), 45 DCR 745; Apr. 20, 1999, D.C. Law 12-264, § 57(e), 46 DCR 2118; June 11, 2004, D.C. Law 15-166, § 4(i)(5), 51 DCR 2817.)

Section references. — This section is referred to in § 31-1317.

Prior Codifications. — 1981 Ed., § 35-2819.

Effect of amendments. — D.C. Law 15-166, in par. (5) of subsec. (a), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities” both times it appears.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(i)(5) of Consolidation of Financial Services Emergency

Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-255. — For legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-1301.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 12-264. — Law 12-264, the “Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998,” was introduced in Council and assigned Bill

No. 12-804, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on November 10, 1998, and December 1, 1998, respectively. Signed by the Mayor on January 7, 1999, it was assigned Act No. 12-626, and transmitted to both Houses of Congress for review. D.C. Law 12-264 became effective on April 20, 1999.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-1320. Notice to creditors and others.

(a) Unless the court otherwise directs, the liquidator shall give, or cause to be given, notice of the liquidation order as soon as possible:

(1) By first class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

(2) By first class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(3) By first class mail to all insurance agents of the insurer;

(4) By first class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known address as indicated by the records of the insurer; and

(5) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in other locations the liquidator deems appropriate.

(b) Notice to potential claimants under subsection (a) of this section shall require claimants to file with the liquidator their claims, together with proper proofs under § 31-1334, on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be no later than 18 months following the order of liquidation. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(c)(1) Notice under subsection (a) of this section to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(2) The liquidator shall promptly provide to the guaranty associations any information concerning the identities and addresses of the policyholders and their policy coverages as may be within the liquidator’s possession or control, and otherwise cooperate with guaranty associations to assist them in providing to the policyholders timely notice of the guaranty associations’ coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(d) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

(Oct. 15, 1993, D.C. Law 10-35, § 21, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1321, 31-1333, and 31-1336.
Prior Codifications. — 1981 Ed., § 35-2820.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1321. Duties of agents.

(a) Every person who receives notice in the form prescribed in § 31-1320 that an insurer which he represents as an agent is the subject of a liquidation order shall, within 30 days of the notice, provide to the liquidator (in addition to the information he may be required to provide pursuant to § 31-1305) the information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to him or her, including the name and address of such subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his or her possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(b) Any agent failing to provide information to the liquidator as required in subsection (a) of this section may be subject to payment of a penalty of not more than \$1,000 and may have his or her licenses suspended, the penalty to be imposed after a hearing held by the Commissioner.

(Oct. 15, 1993, D.C. Law 10-35, § 22, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2821.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1322. Actions by and against liquidator.

(a) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in the District, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in the District or elsewhere, nor shall any existing actions be maintained or further presented after issuance of the order. The courts of the District shall give full faith and credit to injunctions against the liquidator or the company, or the continuation of existing actions against the liquidator or the company, when the injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside the District, he or she may intervene in the action. The liquidator may defend any action in which he or she intervenes under this section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within 2 years, or other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in such a case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any action or do any act required of or permitted to the insurer within a period of 180 days subsequent to the entry of an order for liquidation, or within any further period shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the petition is denied.

(d) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if the association is or may become liable to act as a result of the liquidation.

(Oct. 15, 1993, D.C. Law 10-35, § 23, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2822.

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

CASE NOTES

ANALYSIS

Creditors.

Injunctions.

Creditors.

Abstention doctrine required dismissal of suit by creditor of insolvent insurer against government official alleging breach of fiduciary duty, tortious interference with contract and civil rights violation in connection with creditor's dealings with insurer, where liquidation proceedings were pending in court in insurer's state of domicile. *McCarran-Ferguson Act*, § 1 et seq., 15 U.S.C. § 1011 et seq. *Argon Fin. Group v. Marro*, 897 F. Supp. 568, 1995 U.S. Dist. LEXIS 17404 (1995).

No fiduciary duty was owed by government official to creditor and "interested investor" of insolvent insurer who was not policyholder. *Argon Fin. Group v. Marro*, 897 F. Supp. 568, 1995 U.S. Dist. LEXIS 17404 (1995).

Failure of creditor of insolvent insurer to obtain prior regulatory and judicial approval in insurer's state of domicile for alleged agreement to purchase insurer barred creditor's tortious interference with contract claim against government official regarding the alleged agreement. *Argon Fin. Group v. Marro*, 897 F. Supp. 568, 1995 U.S. Dist. LEXIS 17404 (1995).

Injunctions.

Statute requiring courts to give full faith and credit to injunctions included in insurer liquidation orders of foreign states precluded suit by creditor of insolvent insurer against government official alleging breach of fiduciary duty, tortious interference with contract and civil rights violation in connection with creditor's dealings with insurer, where court in insurer's state of domicile had entered liquidation and injunction order prohibiting other proceedings against or concerning liquidation of insurer.

D.C. Code 1981, § 35-2822. *Argon Fin. Group v. Marro*, 897 F. Supp. 568, 1995 U.S. Dist. LEXIS 17404 (1995).

§ 31-1323. Collection and list of assets.

(a) As soon as practicable after the liquidation order, but not later than 120 days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the Clerk of the Superior Court of the District of Columbia, and 1 copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(c) A submission to the court for disbursement of assets in accordance with § 31-1332 fulfills the requirements of subsection (a) of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 24, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2823. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-

Legislative history of Law 10-35. — For 1301.

§ 31-1324. Fraudulent transfer prior to petition.

(a) Every transfer made or suffered and every obligation incurred by an insurer within 1 year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for the transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order such a transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under § 31-1326(c).

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquida-

tion shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) of this section if:

(1) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction took place within 1 year prior to the date of filing of the petition through which the receivership was commenced.

(d) Every person receiving any property from the insurer, or any benefit thereof, which is a fraudulent transfer under subsection (a) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(Oct. 15, 1993, D.C. Law 10-35, § 25, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1312 and 31-1333.

Prior Codifications. — 1981 Ed., § 35-2824.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1325. Fraudulent transfer after petition.

(a) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually

paid, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his or her order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (a) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(d) Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

(Oct. 15, 1993, D.C. Law 10-35, § 26, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1312, 31-1319, and 31-1333.

Prior Codifications. — 1981 Ed., § 35-2825.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1326. Voidable preferences and liens.

(a)(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within 1 year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then the transfers shall be deemed preferences if made or suffered within 1 year before the filing of the successful petition for rehabilitation, or within 2 years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(A) The insurer was insolvent at the time of the transfer;

(B) The transfer was made within 4 months before the filing of the petition;

(C) The creditor receiving it or to be benefitted thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(D) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he or she held such a position, or any

shareholder holding directly or indirectly more than 5% of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, he or she shall have a lien upon the property to the extent of the consideration actually given by him or her. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(c)(1) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of the proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(2) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (b) of this section, if the consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (b) of this section through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(d) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (b) of this section to be made

or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within 21 days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(e) If any lien deemed voidable under subsection (a)(2) of this section has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this chapter which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(f) The property affected by any lien deemed voidable under subsections (a) and (e) of this section shall be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order such a lien to be preserved for the benefit of the estate and the court may direct that such a conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(g) The Superior Court of the District of Columbia shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnified or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within a reasonable time as the court shall fix.

(h) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or, where the property is retained under subsection (g) of this section, to the extent of the amount paid to the liquidator.

(i) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

(j) If an insurer, directly or indirectly, within 4 months before the filing of a successful petition for liquidation under this chapter, or at any time in contemplation of a proceeding to liquidate it, pays money or transfers property to an attorney-at-law for services rendered or to be rendered, the transactions

may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provisions of subsection (a)(2)(D) of this section.

(k)(1) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he or she has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within 4 months before the date of filing of this successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (a) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(3) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

(Oct. 15, 1993, D.C. Law 10-35, § 27, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1319, 31-1324, and 31-1333.

Prior Codifications. — 1981 Ed., § 35-2826.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1327. Claims of holders of void or voidable rights.

(a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter shall be allowed unless he or she surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) of this section by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused last filing under § 31-1333 if filed within 30 days from the date of the avoidance, or within the further time allowed by the court under subsection (a) of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 28, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1333.

Prior Codifications. — 1981 Ed., § 35-2827.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1328. Setoffs.

(a) Mutual debts or mutual credits, whether arising out of 1 or more contracts between the insurer and another person in connection with any action or proceeding under this chapter, shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) of this section and § 31-1331.

(b) No setoff shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not at the date of the filing of a petition for receivership entitle the person to share as a claimant in the assets of the insurer;

(2) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) The obligation of the insurer is owed to an affiliate of the person, or any other entity or association other than the person;

(4) The obligation of the person is owed to an affiliate of the insurer, or any other entity or association other than the insurer;

(5) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is in any other way in the nature of a capital contribution; or

(6) The obligations between the person and the insurer arise from business where either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations.

(c) The receiver shall provide persons with accounting statements identifying all debts which are due and payable. Where a person owes to the insurer amounts which are due and payable, against which the person asserts setoff of mutual credits which may become due and payable from the insurer in the future, the person shall promptly pay to the receiver the amounts due and payable; provided that, notwithstanding § 31-1340 or any other provision of this chapter, the receiver shall promptly and fully refund, to the extent of the person's prior payments, any mutual credits that become due and payable to the person by the insurer. Prior to the termination of any proceeding under this chapter, the amount due the person shall be determined for the purpose of the receiver making a final refund, if any.

(d) These amendments shall be effective October 15, 1994 and shall apply to all contracts entered into, renewed, extended, or amended on or after that date, and to debts or credits arising from any business written or transactions occurring after the effective date pursuant to any such contract. For purposes of this section, any change in the terms of, or consideration for, any such contract shall be deemed an amendment.

(Oct. 15, 1993, D.C. Law 10-35, § 29, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2828.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Editor's notes. — Application of Law 10-35: Section 60 of D.C. Law 10-35 provided that § 35-2828 § 31-1328, 2001 Ed. shall apply 6 months from the effective date of this act and shall apply to all contracts entered into, re-

newed, extended, or amended, including any change in the terms of, or consideration for, such a contract on or after that date, and to debts or credits arising from any business written or transaction occurring after the effective date pursuant to any contract, including those in existence prior to the effective date, and shall supersede any agreement or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer.

§ 31-1329. Assessments.

(a) As soon as practicable but not more than 2 years from the date of an order of liquidation under § 31-1316 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

- (1) The reasonable value of the assets of the insurer;
- (2) The insurer's probable total liabilities;
- (3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and
- (4) A recommendation as to whether or not an assessment should be made and in what amount.

(b)(1) Upon the basis of the report provided in subsection (a) of this section, including any supplements and amendments, the Superior Court of the District of Columbia may levy 1 or more assessments against all members of the insurer who are subject to assessment.

(2) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(c) After the levy of assessment under subsection (b) of this section, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(d) The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable mailed to his or her last known address as it appears on the insurer's records, at least 20 days before the return date of the order to show cause.

(e)(1) If a member does not appear and serve duly verified objections upon the liquidator on or before the return date of the order to show cause under subsection (c) of this section, the court shall issue an order adjudging the member liable for the amount of the assessment against him or her pursuant to subsection (c) of this section, together with costs, and the liquidator shall have a judgment against the member.

(2) If on or before the return date, the member appears and serves duly verified objections upon the liquidator, the Commissioner may hear and determine the matter, or may appoint a referee to hear it, and issue such an

order as the facts warrant. In the event that the Commissioner determines that the objections do not warrant relief from assessment, the member may request that the court review the matter and vacate the order to show cause.

(f) The liquidator may enforce any order or collect any judgment under subsection (e) of this section by any lawful means.

(Oct. 15, 1993, D.C. Law 10-35, § 30, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2829.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1330. Reinsurer's liability.

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contracts or other agreements. The reinsurance shall be payable under contracts reinsured by the assuming insurer on the basis of reported claims allowed by the Superior Court of the District of Columbia, without diminution because of the insolvency of the ceding insurer. The payments shall be made directly to the ceding insurer or to its domiciliary liquidator, except where:

(1) The contracts or other written agreements specifically provide for another payee of the reinsurance in the event of the insolvency of the ceding insurer; or

(2) The assuming insurer, with the consent of the direct insureds, has assumed the policy obligations of the ceding insurer as the direct obligation of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to the payees.

(Oct. 15, 1993, D.C. Law 10-35, § 31, 40 DCR 5773; Oct. 21, 2000, D.C. Law 13-185, § 2, 47 DCR 7068.)

Prior Codifications. — 1981 Ed., § 35-2830.

Effect of amendments. — D.C. Law 13-185 rewrote this section which prior thereto provided: "The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation."

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 13-185. — Law 13-185, the "Reinsurance Credit and Recovery Act of 2000," was introduced in Council and assigned Bill No. 13-595, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 2, 2000, it was assigned Act No. 13-401 and transmitted to both Houses of Congress for its review. D.C. Law 13-185 became effective on October 21, 2000.

§ 31-1331. Recovery of premiums owed.

(a)(1) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such a person any part of an unearned premium that represents the commission of such a person. Credits or setoffs, or both, shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(2) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(b) Upon satisfactory evidence of a violation of this section, the Commissioner may pursue either one or both of the following courses of action:

(1) Suspend, revoke, or refuse to renew the licenses of the offending party or parties; or

(2) Impose a penalty of not more than \$1,000 for each act in violation of this section by the party or parties.

(c) Before the Commissioner takes any action as set forth in subsection (b) of this section, he or she shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time and place, at least 10 days thereafter, when a hearing on the matter shall be held. After the hearing, or upon failure of the accused to appear at the hearing, the Commissioner, if he or she finds the violation, shall impose any of the penalties under subsection (b) of this section as he or she deems advisable.

(d) When the Commissioner takes action in any or all of the ways set out in subsection (b) of this section, the party aggrieved may appeal from the action to the Superior Court of the District of Columbia.

(Oct. 15, 1993, D.C. Law 10-35, § 32, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1328.

Prior Codifications. — 1981 Ed., § 35-2831.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see His-

torical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1332. Domiciliary liquidator's proposal to distribute assets.

(a) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of the District of Columbia, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as the assets become available, to a

guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(b) The proposal required by subsection (a) of this section shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in § 31-1340, classes 1 and 2;

(2) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(3) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(4) The securing by the liquidator, from each of the associations entitled to disbursements pursuant to this section, of an agreement to return to the liquidator those assets, together with income earned on assets previously disbursed, required to pay claims of secured creditors and claims falling within the priorities established in § 31-1340 in accordance with those priorities. No bond shall be required of such an association; and

(5) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on the assets, and any other matter the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which the associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of the claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(d) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities, or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating the associations.

(e) Notice of the application shall be given to the association in and to the commissioners of insurance of each of the states. Such a notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least 30 days prior to submission of the application to the court. Action on the application may be taken by the court provided the above required notice has been given, and, provided further, that the liquidator's proposal complies with subsection (b)(1) and (2) of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 33, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1323.

Prior Codifications. — 1981 Ed., § 35-2832.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1333. Filing of claims.

(a) Proof of all claims shall be filed with the liquidator in the form required by § 31-1334 on or before the last day for filing specified in the notice required under § 31-1320, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he or she were not late, to the extent that such a payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) The existence of the claim was not known to the claimant and that he or she filed his or her claim as promptly thereafter as reasonably possible after learning of it;

(2) A transfer to a creditor was avoided under §§ 31-1324 through 31-1326, or was voluntarily surrendered under § 31-1327, and that the filing satisfies the conditions of § 31-1327; or

(3) The valuation under § 31-1339 of security held by a secured creditor shows a deficiency, which is filed within 30 days after the valuation.

(c) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if the claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where the payments were made and expenses incurred as provided by law.

(d) The liquidator may consider any claim filed late, which is not covered by subsection (b) of this section, and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his or her claim as is then being paid to claimants of any lower priority. This shall continue until his or her claim has been paid in full.

(Oct. 15, 1993, D.C. Law 10-35, § 34, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1327, 31-1335, and 31-1354.

Prior Codifications. — 1981 Ed., § 35-2833.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1334. Proof of claim.

(a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

- (2) The identity and amount of the security on the claim;
- (3) The payments made on the debt, if any;
- (4) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;
- (5) Any right of priority of payment or other specific right asserted by the claimants;
- (6) A copy of the written instrument which is the foundation of the claim; and
- (7) The name and address of the claimant and the attorney who represents him or her, if any.

(b) No claim need be considered or allowed if it does not contain all the information in subsection (a) of this section which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(c) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) of this section and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(d) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion, need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within 4 months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(e) All claims of a guaranty association or foreign guaranty association shall be in the form and contain the substantiation agreed to by the association and the liquidator.

(Oct. 15, 1993, D.C. Law 10-35, § 35, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1320, 31-1333, and 31-1354.
Prior Codifications. — 1981 Ed., § 35-2834.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1335. Special claims.

(a) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no contingency.

(b) A claim may be allowed even if contingent, if it is filed in accordance with § 31-1333. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(c) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that the claims may be discounted at the legal rate of interest.

(d) Claims made under employment contracts by directors, principal offi-

cers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under § 31-1311 or § 31-1316.

(Oct. 15, 1993, D.C. Law 10-35, § 36, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1316.

Prior Codifications. — 1981 Ed., § 35-2835.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1336. Special provisions for third party claims.

(a) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on his or her own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within 60 days after mailing of the notice required by § 31-1320, whichever is later, he or she is an unexcused late filer.

(c) The liquidator shall make his or her recommendations to the court under § 31-1340 for the allowance of an insured's claim under subsection (b) of this section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he or she shall reconsider the claim on the basis of additional information and amend his or her recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of the amount actually recovered from the insured by action, or paid by agreement, plus the reasonable costs and expense of defense, or the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(d) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (c) of this section. If any insured's claim is subsequently reduced under subsection (c) of this section, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(e) No claim may be presented under this section if it is, or may be, covered by any guaranty association or foreign guaranty association.

(Oct. 15, 1993, D.C. Law 10-35, § 37, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2836. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For

§ 31-1337. Disputed claims.

(a) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant, or his or her attorney, by first class mail at the address shown in the proof of claim. Within 60 days from the mailing of the notice, the claimant may file his or her objections with the liquidator. If no filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator and the liquidator does not alter his or her denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant, or his or her attorney, and to any other persons directly affected, not less than 10 nor more than 30 days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his or her recommendation.

(Oct. 15, 1993, D.C. Law 10-35, § 38, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1341 and 31-1354.

Prior Codifications. — 1981 Ed., § 35-2837.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1338. Claims of surety.

Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he or she discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution, however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person", as used in this section, is not intended to apply to a guaranty association or foreign guaranty association.

(Oct. 15, 1993, D.C. Law 10-35, § 39, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2838.

Legislative history of Law 10-35. — For

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1339. Secured creditor's claims.

(a) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to the creditors; or

(2) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(b) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his or her security to the liquidator, the entire claim shall be allowed as if unsecured.

(Oct. 15, 1993, D.C. Law 10-35, § 40, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1333 and 31-1356.

Prior Codifications. — 1981 Ed., § 35-2839.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1340. Priority of distribution.

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this chapter. Every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including, but not limited to the following:

(A) The actual and necessary costs of preserving or recovering the assets of the insurer;

(B) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(C) Any necessary filing fees;

(D) The fees and mileage payable to witnesses;

(E) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation; and

(F) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

(2) Class 2. All claims under policies including the claims of the federal or any state or local government for losses incurred ("loss claims"), including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as

loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support, by way of succession at death, as proceeds of life insurance, or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity.

(3) Class 3. Claims of the federal or any state or local government, except those under Class 2. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of the claims shall be postponed to the class of claims under paragraph (8) of this section.

(4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed 2 months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. This priority shall be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(5) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming companies in their capacity as general creditors.

(6) Class 6. Claims filed late or any other claims other than claims under paragraphs (7) and (8) of this section.

(7) Class 7. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(8) Class 8. The claims of shareholders or other owners in their capacity as shareholders.

(Oct. 15, 1993, D.C. Law 10-35, § 41, 40 DCR 5773; Mar. 8, 2007, D.C. Law 16-232, § 201, 54 DCR 368.)

Section references. — This section is referred to in §§ 31-1319, 31-1328, 31-1332, 31-1336, 31-1343, 31-1353, 31-1357, and 31-3932.06.

Prior Codifications. — 1981 Ed., § 35-2840.

Effect of amendments. — D.C. Law 16-232 rewrote pars. (2) to (5), which formerly read:

“(2) Class 2. Reasonable compensation to employees for services performed to the extent that they do not exceed 2 months of monetary compensation and represent payment for services performed within 1 year before the filing of the petition for liquidation, or, if rehabilitation preceded liquidation, within 1 year before the filing of the petition for rehabilitation. Prin-

cipal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such a priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

“(3) Class 3. All claims under policies including the claims of the federal or any state or local government for losses incurred (‘loss claims’), including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by

other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity.

“(4) Class 4. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming companies in their capacity as general creditors.

“(5) Class 5. Claims of the federal or any state or local government, except those under Class

3. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of the claims shall be postponed to the class of claims under paragraph (8) of this section.”

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

§ 31-1341. Liquidator's recommendations to the court.

(a) The liquidator shall review all claims duly filed in the liquidation and shall make any further investigation he or she deems necessary. He or she may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court, except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under § 31-1337. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with his or her recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(b) The court may approve, disapprove, or modify the report on claims by the liquidator. The reports not modified by the court within a period of 60 days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject to later modification or to rulings made by the court pursuant to § 31-1337. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

(Oct. 15, 1993, D.C. Law 10-35, § 42, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1354.

Prior Codifications. — 1981 Ed., § 35-2841.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1342. Distribution of assets.

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims.

Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

(Oct. 15, 1993, D.C. Law 10-35, § 43, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2842.

legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For

§ 31-1343. Unclaimed and withheld funds.

(a) All unclaimed funds subject to distribution remaining in the liquidator's hands when he or she is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the District of Columbia, and shall be paid without interest, except in accordance with § 31-1340, to the person entitled thereto or his or her legal representative upon proof satisfactory to the District of Columbia Treasurer of his or her right thereto. Any amount on deposit and not claimed at the time of the discharge of the liquidator shall be distributed in accordance with Chapter 1 of Title 41.

(b) All funds withheld under § 31-1336 and not distributed shall, upon discharge of the liquidator, be deposited with the District of Columbia Treasurer and paid by him or her in accordance with § 31-1340. Any sums remaining, which under § 31-1340 would revert to the undistributed assets of the insurer, shall be transferred to the District of Columbia Treasurer and become the property of the District under subsection (a) of this section, unless the Commissioner in his or her discretion petitions the court to reopen the liquidation under § 31-1345.

(Oct. 15, 1993, D.C. Law 10-35, § 44, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2843.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1344. Termination of proceedings.

(a) When all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, deemed appropriate.

(b) Any other person may apply to the court at any time for an order under subsection (a) of this section. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

(Oct. 15, 1993, D.C. Law 10-35, § 45, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2844. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For

§ 31-1345. Reopening liquidation.

After the liquidation proceeding has been terminated and the liquidator discharged, the Commissioner or other interested party may at any time petition the Superior Court of the District of Columbia to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

(Oct. 15, 1993, D.C. Law 10-35, § 46, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1343. torical and Statutory Notes following § 31-1301.

Prior Codifications. — 1981 Ed., § 35-2845. **Legislative history of Law 11-268.** — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see His-

§ 31-1346. Disposition of records during and after termination of liquidation.

Whenever it shall appear to the Commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he or she may recommend to the court, and the court shall direct, what records should be retained for future reference and what records should be destroyed.

(Oct. 15, 1993, D.C. Law 10-35, § 47, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2846.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1347. External audit of the receiver's books.

The Superior Court of the District of Columbia may, as it deems desirable, order audits to be made of the books of the Commissioner relating to any receivership established under this chapter, and a report of each audit shall be filed with the Commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

(Oct. 15, 1993, D.C. Law 10-35, § 48, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2847.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1348. Conservation of property of foreign or alien insurers found in the District of Columbia.

(a) If a domiciliary liquidator has not been appointed, the Commissioner may apply to the Superior Court of the District of Columbia by verified petition for an order directing him or her to act as conservator to conserve the property of an alien insurer not domiciled in the District, or a foreign insurer, on any one or more of the following grounds:

(1) Any of the grounds in § 31-1310;

(2) That any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; or

(4)(A) That its certificate of authority to do business in the District has been revoked or that none was ever issued; and

(B) That there are residents of the District with outstanding claims or outstanding policies.

(b) When an order is sought under subsection (a) of this section, the court shall cause the insurer to be given notice and time to respond reasonable under the circumstances.

(c) The court may issue the order in whatever terms it deems appropriate. The filing or recording of the order with the Clerk of the Superior Court of the District of Columbia shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) The conservator may at any time petition for, and the court may grant, an order under § 31-1349 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under § 31-1351 to be appointed ancillary receiver.

(e) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and control of its business. The court may also make such a finding and issue such an order at any time upon motion of any interested party, but, if the motion is denied, all costs shall be assessed against the interested party.

(Oct. 15, 1993, D.C. Law 10-35, § 49, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in §§ 31-1349 and 31-1350.

Prior Codifications. — 1981 Ed., § 35-2848.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1349. Liquidation of property of foreign or alien insurers found in the District of Columbia.

(a) If no domiciliary receiver has been appointed, the Commissioner may apply to the Superior Court of the District of Columbia by verified petition for an order directing him or her to liquidate the assets, found in the District, of a foreign insurer or an alien insurer not domiciled in the District, on any of the following grounds:

(1) Any of the grounds in § 31-1310 or § 31-1315; or

(2) Any of the grounds specified in § 31-1348(a)(2) through (4).

(b) When an order is sought under subsection (a) of this section, the court shall cause the insurer to be given notice and time to respond reasonable under the circumstances.

(c) If it appears to the court that the best interests of creditors, policyholders, and the public so require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the Superior Court of the District of Columbia or the recorder of deeds of the District of Columbia shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under § 31-1351. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under § 31-1351.

(e) On the same grounds as are specified in subsection (a) of this section, the Commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the Commissioner deems desirable for the protection of the policyholders and creditors in the District.

(f) The court may order the Commissioner, when he or she has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of the District against the insurer under rules concerning liquidation of insurers under this chapter as are otherwise compatible with the provisions of this section.

(Oct. 15, 1993, D.C. Law 10-35, § 50, 40 DCR 5773; Feb. 27, 1996, D.C. Law 11-90, § 2, 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in §§ 31-1348 and 31-1350.

Prior Codifications. — 1981 Ed., § 35-2849.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 2 of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 2 of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19,

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-90. — Law 11-90, the “Insurance Omnibus Amendment Act of 1995,” was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1350. Domiciliary liquidators in other states.

(a) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under § 31-1351(c), be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, agents’ balances, and all of the books, accounts, and other records of the insurer located in the District. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to § 31-1351.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the Commissioner shall be vested by operation of law with the title to all of the property, contracts, and right of action, and all of the books, accounts and other records of the insurer located in the District, at the same time that the domiciliary liquidator is vested with title in the domicile. The Commissioner may petition for a conservation or liquidation order under § 31-1348 or § 31-1349, or for an ancillary receivership under § 31-1351, or, after approval by the Superior Court of the District of Columbia, may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in the District may file claims with the liquidator or ancillary receiver, if any, in the District or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

(Oct. 15, 1993, D.C. Law 10-35, § 51, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1301.

Prior Codifications. — 1981 Ed., § 35-2850.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1351. Ancillary formal proceedings.

(a) If a domiciliary liquidator has been appointed for an insurer not domiciled in the District, the Commissioner may file a petition with the Superior Court of the District of Columbia requesting appointment as ancillary receiver in the District:

(1) If he or she finds that there are sufficient assets of the insurer located in the District to justify the appointment of an ancillary receiver; or

(2) If the protection of creditors or policyholders in the District so requires.

(b) The court may issue an order appointing an ancillary receiver in whatever terms it deems appropriate. The filing or recording of the order with the recorder of deeds in the District imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in the District may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in the District. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in the District, and shall pay the necessary expenses of the proceedings. He or she shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in the District.

(d) When a domiciliary liquidator has been appointed in the District, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection (c) of this section for ancillary receivers appointed in the District.

(Oct. 15, 1993, D.C. Law 10-35, § 52, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Section references. — This section is referred to in §§ 31-1301, 31-1348, 31-1349, and 31-1350.

Prior Codifications. — 1981 Ed., § 35-2851.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see His-

torical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1352. Ancillary summary proceedings.

The Commissioner, in his or her sole discretion, may institute proceedings

under §§ 31-1308 and 31-1309 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in the District.

(Oct. 15, 1993, D.C. Law 10-35, § 53, 40 DCR 5773; May 21, 1997, D.C. Law 11-268, § 10(z)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2852.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1301.

§ 31-1353. Claims of nonresidents against insurers domiciled in the District of Columbia.

(a) In a liquidation proceeding begun in the District against an insurer domiciled in the District, claimants residing in foreign countries or in states not reciprocal states must file claims in the District, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in the District as provided in this chapter, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of the District as provided in § 31-1354(b) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and priority against special deposits or other security located in ancillary states, but shall not be conclusive with respect to priorities against general assets under § 31-1340.

(Oct. 15, 1993, D.C. Law 10-35, § 54, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1301.

Prior Codifications. — 1981 Ed., § 35-2853.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1354. Claims of residents against insurers domiciled in reciprocal states.

(a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within the District may file claims either with the ancillary receiver, if any, in the District, or with the domiciliary liquidator. Claims must be filed by the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in the District may be proved either in the domiciliary state under the law of that state, or in ancillary

proceedings, if any, in the District. If a claimant elects to prove his or her claim in the District, the claimant shall file his or her claim with the liquidator in the manner provided in §§ 31-1333 and 31-1334. The ancillary receiver shall make his or her recommendation to the court as under § 31-1341. He or she shall also arrange a date for hearing if necessary under § 31-1337 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least 40 days prior to the date set for hearing. If the domiciliary liquidator, within 30 days after the giving of notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his or her intention to contest the claim, he or she shall be entitled to appear or to be represented in any proceeding in the District involving the adjudication of the claim.

(c) The final allowance of the claim by the courts of the District shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in the District.

(Oct. 15, 1993, D.C. Law 10-35, § 55, 40 DCR 5773.)

Section references. — This section is referred to in §§ 31-1301 and 31-1353.

Prior Codifications. — 1981 Ed., § 35-2854.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1355. Attachment, garnishment, and levy of execution.

During the pendency in this, or any other state, of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in the District against the delinquent insurer or its assets.

(Oct. 15, 1993, D.C. Law 10-35, § 56, 40 DCR 5773.)

Section references. — This section is referred to in § 31-1301.

Prior Codifications. — 1981 Ed., § 35-2855.

Legislative history of Law 10-35. — For legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.

§ 31-1356. Interstate priorities.

(a) In a liquidation proceeding in the District involving 1 or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where the assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors,

and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secure claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his or her security and file his or her claim as a general creditor, or the claim may be discharged by resort to the security in accordance with § 31-1339, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

(Oct. 15, 1993, D.C. Law 10-35, § 57, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2856. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.
Legislative history of Law 10-35. — For

§ 31-1357. Subordination of claims for noncooperation.

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in the District any assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under § 31-1340(7).

(Oct. 15, 1993, D.C. Law 10-35, § 58, 40 DCR 5773.)

Prior Codifications. — 1981 Ed., § 35-2857. legislative history of D.C. Law 10-35, see Historical and Statutory Notes following § 31-1301.
Legislative history of Law 10-35. — For

CHAPTER 13A. INVESTMENTS OF INSURERS.

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Subchapter V. Regulations

- 31-1375.01. Regulations.

*Subchapter I. General Provisions.***§ 31-1371.01. Application.**

This chapter shall apply only to investments and investment practices of domestic insurers and United States branches of non-U.S. insurers that are authorized to use the District of Columbia as a state of entry to transact insurance through its United States branch under § 31-2202. This chapter shall not apply to separate accounts of an insurer pertaining to variable or modified guaranteed contracts.

(Apr. 11, 2003, D.C. Law 14-297, § 101, 50 DCR 330.)

Legislative history of Law 14-297. — Law 14-297, the “Investments of Insurers Act of 2002”, was introduced in Council and assigned Bill No. 14-222, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 23, 2002, it was assigned Act No. 14-573 and transmitted to both Houses of Congress for its review. D.C. Law 14-297 became effective on April 11, 2003.

§ 31-1371.02. Definitions.

For the purposes of this chapter, the term:

(1) “Acceptable collateral” means:

(A) As to securities lending transactions, and for the purpose of calculating the counterparty exposure amount, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States, any agency of the United States, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation;

(B) As to foreign lending securities transactions, investments set forth in subparagraph (A) of this paragraph and sovereign debt rated 1 by the SVO;

(C) As to repurchase transactions, cash, cash equivalents and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States, an agency of the United States, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation; and

(D) As to reverse repurchase transactions, cash and cash equivalents.

(2) “Acceptable private mortgage insurance” means insurance written by a private insurer protecting a mortgage lender against loss occasioned by a mortgage loan default and issued by a licensed mortgage insurance company, with an SVO 1 designation or a rating issued by a nationally recognized statistical rating organization equivalent to an SVO 1 designation, that covers losses to an 80% loan-to-value ratio.

(3) “Accident and health insurance” means protection which provides payment of benefits for covered sickness or accidental injury, excluding credit insurance, disability insurance, accidental death and dismemberment insurance, and long-term care insurance.

(4) “Accident and health insurer” means a licensed life or health insurer or health service corporation whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively.

(5) “Admitted assets” means assets having economic value which can be used to fulfill policy obligations and permitted, as allowed in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the Commissioner, but excluding assets of separate accounts, the investments of which are not subject to the provisions of this chapter.

(6) “Affiliate” means, as to any person, another person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(7) “Asset-backed security” means a security or other instrument, excluding a mutual fund, evidencing an interest in, providing the right to receive payments from, or payable from distributions on, an asset, a pool of assets, or specifically divisible cash flows which are legally transferred to a trust or another special purpose bankruptcy-remote business entity, under the following conditions:

(A) The trust or other business entity is established solely for the purpose of acquiring specific types of assets or right to cash flows, issuing

securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

(B) The assets of the trust or other business entity consist solely of interest-bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights; provided, that the existence of credit enhancements, such as letters of credit or guarantees, or support features, such as swap agreements, shall not disqualify the security or other instrument as an asset-backed security.

(8) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for profit or not for profit.

(9) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the strike rate or strike price.

(10) "Capital and surplus" means the sum of the capital and surplus of the insurer required to be shown on the statutory financial statement of the insurer most recently required to be filed with the Commissioner.

(11) "Cash equivalents" means short-term, highly rated, and highly liquid investments or securities readily convertible to known amounts of cash without penalty. Cash equivalents shall include government money market mutual funds and class one money market mutual funds. For the purposes of this definition:

(A) "Short-term" means investments with a remaining term to maturity of 90 days or less.

(B) "Highly rated" means an investment rated P-1 by Moody's Investors Services, Inc., A-1 by the Standard and Poor's division of The McGraw Hill Companies, Inc., or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

(12) "Class one bond mutual fund" means a bond mutual fund that at all times qualifies for investment using the bond class one reserve factor under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(13) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one reserve factor under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(14) "Code" means the laws relating to insurance which are codified in this title of the D.C. Official Code.

(15) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(16) "Commercial mortgage loan" means a loan secured by a mortgage other than a residential mortgage loan.

(17) “Construction loan” means a loan with a term of less than 3 years made for financing the cost of construction of a building or other improvement to real estate and secured by the real estate to be improved.

(18) “Control” means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or non-management services), or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The Commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(19)(A) “Counterparty exposure amount” means the net amount of credit risk attributable to a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearinghouse (“over-the-counter derivative instrument”).

(B)(i) The net amount of credit risk equals:

(I) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(II) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(ii) If over-the-counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective parties, and the domiciliary jurisdiction of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the *Purposes and Procedures of the Securities Valuation Office* as eligible for netting, the net amount of credit risk shall be the greater of zero or the net sum of:

(I) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(II) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(iii) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer’s fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(20) “Covered” means that, in an income generation transaction, an insurer owns or can immediately acquire, through the exercise of options, warrants, or conversion rights already owned, the underlying interest to fulfill or secure its obligations under a call option, cap, or floor it has written, or has

set aside under a custodial or escrow agreement cash or cash equivalents with a market value equal to the amount required to fulfill its obligations under a put option it has written.

(21) "Credit tenant loan" means a mortgage loan which is made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender, and is secured by a first lien on the real estate.

(22)(A) "Derivative instrument" means an agreement, option, instrument, or a series or combination thereof:

(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests;

(ii) To make a cash settlement in lieu thereof; or

(iii) That has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(B) Derivative instruments shall include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, and futures; any other agreements, options, or instruments substantially similar thereto, or any series or combination thereof; and any agreements, options, or instruments permitted under regulations adopted under § 31-1375.01. Derivative instruments shall not include an investment authorized by §§ 31-1372.03 through 31-1372.09, 31-1372.11, and 31-1373.04 through 31-1373.10.

(23) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(24) "Direct" or "directly", when used in connection with an obligation, means that the designated obligor is primarily liable on the instrument representing the obligation.

(25) "Dollar roll transaction" means 2 simultaneous transactions with different settlement dates no more than 96 days apart, where, in the first transaction, an insurer sells to a business entity and, in the second transaction, the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(A) Asset-backed securities issued, assumed, or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation, or their respective successors; and

(B) Other asset-backed securities referred to in section 106 of the Secondary Mortgage Market Enhancement Act of 1984, approved October 3, 1984 (98 Stat. 1691; 15 U.S.C. § 77r-1).

(26) "Domestic jurisdiction" means the United States, Canada, the District of Columbia, any state, any province of Canada, or any political subdivision of any of the foregoing.

(27) "Equity interest" means any of the following that are not rated credit instruments:

(A) Common stock;

(B) Preferred stock;

(C) Trust certificate;

(D) Equity investment in an investment company other than a money market mutual fund or a class one bond mutual fund;

(E) Investment in a common trust fund of a bank regulated by a federal or state agency;

(F) An ownership interest in minerals, oil, or gas, the rights to which have been separated from the underlying fee interest in the real estate where the minerals, oil, or gas are located;-

(G) Instruments which are mandatorily, or at the option of the issuer, convertible to equity;

(H) Limited partnership interests and those general partnership interests authorized under § 31-1371.05;

(I) Member interests in limited liability companies;

(J) Warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired; or

(K) Instruments that would be rated credit instruments except as excluded by paragraph (71)(B) of this section.

(28) "Equivalent securities" means:

(A) In a securities lending transaction, securities that are identical to the loaned securities in all features, including the amount of the loaned securities, except as to certificate number if held in physical form; provided, that if any different security shall be exchanged for a loaned security by recapitalization, merger, consolidation, or other corporate action, the different security shall be deemed to be the loaned security;

(B) In a repurchase transaction, securities that are identical to the purchased securities in all features, including the amount of the purchased securities, except as to the certificate number if held in physical form; or

(C) In a reverse repurchase transaction, securities that are identical to the sold securities in all features, including the amount of the sold securities, except as to the certificate number if held in physical form.

(29) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests.

(30) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(31)(A) "Foreign investment" means an investment in a foreign jurisdiction, or any investment in a person, real estate, or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under this chapter, other than under §§ 31-1372.09 and 31-1373.10. An investment shall not be a foreign investment if the issuing person, qualified primary credit source, or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(i) The issuing person is a shell business entity; and

(ii) The investment is not assumed, accepted, guaranteed, insured, or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(B) For the purposes of this definition:

(i) “Shell business entity” means a business entity having no economic substance except as a vehicle for owning interests in assets issued, owned, or previously owned by a person domiciled in a foreign jurisdiction.

(ii) “Qualified guarantor” means a guarantor against which an insurer has a direct claim under contract for full and timely payment for which an enforcement action can be brought in a domestic jurisdiction.

(iii) “Qualified primary credit source” means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim under contract for full and timely payment for which an enforcement action can be brought in a domestic jurisdiction.

(32) “Foreign jurisdiction” means a jurisdiction other than a domestic jurisdiction.

(33) “Forward” means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance, or value of, one or more underlying interests.

(34) “Future” means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests.

(35) “Government money market mutual fund” means a money market mutual fund that at all times:

(A) Invests only in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(B) Qualified for investment without a reserve under the *Purposes and Procedures of the Securities Valuation Office* or any successor publication.

(36) “Government-sponsored enterprise” means a:

(A) Governmental agency; or

(B) Corporation, limited liability company, association, partnership, joint stock company, joint venture, trust, or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose; provided, that this subparagraph shall not apply to any entity or instrumentality which qualifies for exemption under section 501(c)(3) of the Internal Revenue Code of 1986, approved October 26, 1986 (68A Stat. 163; 26 U.S.C. § 501(c)(3)).

(37) “Guaranteed or insured”, when used in connection with an obligation acquired under this chapter, means that the guarantor or insurer has agreed to:

(A) Perform or insure the obligation of the obligor or purchase the obligation; or

(B) Be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, minimum stockholders’ equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(38) “Hedging transaction” means a derivative transaction which is entered into and maintained to reduce:

(A) The risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred, or anticipates acquiring or incurring.

(39) "High grade investment" means a rated credit instrument rated 1 or 2 by the SVO.

(40) "Income" means, as to a security, interest, accrual of discount, dividends, or other distributions, such as rights, tax or assessment credits, warrants, and distributions in kind.

(41) "Income generation transaction" means a derivative transaction involving the writing of covered call option, covered put options, covered caps, or covered floors that is intended to generate income or enhance return.

(42) "Initial margin" means the amount of cash, securities, or other consideration initially required to be deposited to establish a futures position.

(43) "Insurance future" means a future relating to an index or pool that is based on insurance-related items.

(44) "Insurance futures option" means an option on an insurance futures contract.

(45) "Investment company" means an investment company as defined in section 3(a)(1) of the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 867; 15 U.S.C. § 80a-3(a)(1)), and a person described in section 3(c) of the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 867; 15 U.S.C. § 80a-3(c)).

(46) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(47) "Investment practices" means transactions of the types described in § 31-1372.08, § 31-1372.10, § 31-1373.09, or § 31-1373.11.

(48) "Investment subsidiary" means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investment in any asset so that its investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or avoid any other provisions of this chapter applicable to the insurer. For the purposes of this paragraph, the total investment of the insurer shall include:

(A) Direct investment by the insurer in an asset; and

(B) The insurer's proportionate share of an investment in an asset by an investment subsidiary of the insurer, which share shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership interest in the subsidiary.

(49) "Investment strategy" means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investment, and value investing.

(50) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit issued or confirmed by, and payable and presentable at, a financial

institution on the list of financial institutions meeting the standards for issuing letters of credit under the *Purposes and Procedures of the Securities Valuation Office*, or any successor publication. To constitute acceptable collateral for the purposes of § 31-1372.08 and § 31-1373.02, a letter of credit shall have an expiration date beyond the term of the subject transaction.

(51) "Limited liability company" means an entity that is an unincorporated association, having perpetual duration, having one or more members that is organized and existing under Chapter 8 of Title 29, or under the laws of the United States or any state thereof that limits the personal liability of each member to the equity investment of the member in the business entity.

(52) "Lower grade investment" means a rated credit instrument rated 4, 5, or 6 by the SVO.

(53) "Market value" means:

(A) As to cash and a letter of credit, the amount thereof; and

(B) As to a security, as of any date, the price of the security on that date obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income thereon to the extent not included in the price as of that date.

(54) "Medium grade investment" means a rated credit instrument rated 3 by the SVO.

(55) "Modified guaranteed contracts" means a modified guaranteed annuity or modified guaranteed life insurance policy or contract.

(56) "Money market mutual fund" means a mutual fund that meets the conditions of 17 C.F.R. § 270.2a-7.

(57) "Mortgage loan" means an obligation secured by a mortgage, deed of trust, trust deed, or other consensual lien on real estate.

(58) "Multilateral development bank" means an international development organization of which the United States is a member.

(59) "Mutual fund" means an investment company or, in the case of an investment company that is organized as a series company, an investment company series, that is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, approved August 20, 1940 (56 Stat. 789; 15 U.S.C. § 80a-1 et seq.).

(60) "NAIC" means the National Association of Insurance Commissioners.

(61) "Obligation" means a bond, note, debenture, trust certificate, including an equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing, net leases and other evidence of indebtedness for the payment of money (or participations, certificates, or other evidences of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(62)(A) "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(B) “Call option” means the right of the buyer to buy or receive the option.

(C) “Put option” means the right of the buyer to sell or deliver the option.

(63) “Person” means an individual, a business entity, a multilateral development bank, or a government or quasi-governmental body, such as a political subdivision or a government-sponsored enterprise.

(64) “Potential exposure” means the amount determined in accordance with the NAIC Annual Statement Instructions.

(65) “Preferred stock” means stock of a business entity, which stock has a preference in liquidation over the common stock of the business entity.

(66) “Qualified bank” means:

(A) A national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System; or

(B) A bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country’s government or an agency thereof and that at all times is no less than adequately capitalized as determined by the standards adopted by international banking authorities.

(67) “Qualified business entity” means a business entity that is:

(A) An issuer of obligations or preferred stock that are rated 1 or 2 by the SVO or an issuer of obligations, preferred stock, or derivative instruments that are rated the equivalent of 1 or 2 by the SVO or by a nationally recognized statistical rating organization recognized by the SVO; or

(B) A primary dealer in United States government securities, recognized by the Federal Reserve Bank of New York.

(68) “Qualified clearinghouse” means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction such that the parties no longer have credit risk as to each other.

(69) “Qualified exchange” means:

(A) A securities exchange registered as a national securities exchange or a securities market regulated under the Securities Exchange Act of 1934 approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78 et seq.);

(B) A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission;

(C) Private Offerings, Resales and Trading through Automated Linkages (PORTAL);

(D) A designated offshore securities market as defined in 17 C.F.R. § 230.902(b); or

(E) A qualified foreign exchange.

(70) “Qualified foreign exchange” means a foreign exchange, board of trade, or contract market located outside the United States, its territories, or possessions:

(A) That has received regulatory comparability relief under Rule 30.10, Appendix C, 17 C.F.R. Part 30 ("Rule 30.10");

(B) That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under Rule 30.10 as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

(C) Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the Office of General Counsel of the Commodity Futures Trading Commission; provided, that an exchange, board of trade, or contract market that is a qualified foreign exchange under this subparagraph shall only be a qualified foreign exchange as to foreign stock index futures contracts that are the subject of no-action relief.

(71)(A) "Rated credit instrument" means a contractual right to receive cash or another rated credit instrument from another entity which instrument:

(i) Is rated, or required to be rated, by the SVO;

(ii) In the case of an instrument with a maturity not exceeding 397 days, is issued, guaranteed, or insured by an entity that is rated by, or another obligation of such entity is rated by, the SVO or by a nationally recognized statistical rating organization recognized by the SVO;

(iii) In the case of an instrument with a maturity not exceeding 90 days, is issued by a qualified bank;

(iv) Is a share of a class one bond mutual fund; or

(v) Is a share of a money market mutual fund.

(B) The term "rated credit instrument" shall not mean:

(i) An instrument that is mandatorily, or at the option of the issuer, convertible to an equity interest; or

(ii) A security that has a par value and whose terms provide that the issuer's net obligation to repay all or part of the security's par value is determined by reference to the performance of an equity, a commodity, a foreign currency, or an index of equities, commodities, foreign currencies, or combinations thereof.

(72)(A) "Real estate" means:

(i) Real property;

(ii) Interests in real property, such as leaseholds, minerals, and oil and gas that have not been separated from the underlying fee interest;

(iii) Improvements and fixtures located on or in real property; or

(iv) The seller's equity in a contract providing for a deed of real estate.

(B) As to a mortgage on a leasehold estate, real estate shall include the leasehold estate only if it has an unexpired term, including renewal options exercisable at the option of the lessee, extending beyond the scheduled maturity date of the obligation that is secured by a mortgage on the leasehold estate by a period equal to the greater of 20% of the original term of the obligation or 10 years.

(73) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer may acquire under this chapter. A derivative transaction that is entered into as a hedging transaction shall not be considered a replication transaction.

(74) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(75) "Required liabilities" means total liabilities required to be reported on the statutory financial statement of the insurer most recently required to be filed with the Commissioner.

(76) "Residential mortgage loan" means a loan primarily secured by a mortgage on real estate improved with a residence for up to 4 families.

(77) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(78) "Secured location" means the contiguous real estate owned by one person.

(79) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(80) "Series company" means an investment company that is organized as a series company, as defined in SEC Rule 18f-2(a), 17 C.F.R. § 270.18f-2.

(81) "Sinking fund stock" means preferred stock that:

(A) Is subject to a mandatory sinking fund or similar arrangement that will provide for the redemption or open market purchase of the entire issue over a period not longer than 40 years from the date of acquisition; and

(B) Provides for mandatory sinking fund installments or open market purchases commencing not more than 10.5 years from the date of issue, with the sinking fund installments providing for the purchase or redemption, on a cumulative basis commencing 10 years from the date of issue, of at least 2.5% per year of the original number of shares of that issue of preferred stock.

(82) "Special rated credit instrument" means a rated credit instrument that is:

(A) An instrument that is structured so that, if it is held until retired by or on behalf of the issuer, its rate of return, based on its purchase cost and any possible cash flow, may become negative due to reasons other than the credit risk associated with the issuer of the instrument; provided, that a rated credit instrument shall not be a special rated credit instrument under this subsection if it is:

(i) A share in a class one bond mutual fund;

(ii) An instrument, other than an asset-backed security, which:

(I) Has payments of par value fixed as to amount and timing or is callable;

(II) Is payable only at par or greater; and

(III) Has interest or dividend cash flows that are based on either a fixed or variable rate determined by reference to a specified rate or index;

(iii) An instrument, other than an asset-backed security, that has a par value and is purchased at a price no greater than 110% of par value;

(iv) An instrument, including an asset-backed security, whose rate of return would become negative only as a result of a prepayment due to casualty, condemnation or economic obsolescence of collateral, or change of law;

(v) An asset-backed security that relies on collateral that meets the requirements of sub-subparagraph (ii) of this subparagraph, the par value of which collateral:

(I) Is not permitted to be paid sooner than $\frac{1}{2}$ of the remaining term to maturity from the date of acquisition;

(II) Is permitted to be paid prior to maturity only at a premium sufficient to provide a yield to maturity for the investment, considering the amount prepaid and reinvestment rates at the time of early repayment, at least equal to the yield to maturity of the initial investment; or

(III) Is permitted to be paid prior to maturity at a premium at least equal to the yield of a treasury issue of comparable remaining life; or

(vi) An asset-backed security that relies on cash flows from assets that are not prepayable at any time at par value, but is not otherwise governed by sub-subparagraph (v) of this subparagraph, if the asset-backed security has par value reflecting principal payments to be received if held until retired by or on behalf of the issuer and is purchased at a price not greater than 105% of such par amount; or

(B)(i) An asset-backed security that:

(I) Relies on cash flows from assets that are prepayable at par value at any time;

(II) Does not make payments of par value that are fixed as to amount and timing; and

(III) Has a negative rate of return at the time of acquisition if a prepayment threshold assumption is used, with the prepayment threshold assumption defined as:

(aa) Twice the prepayment expectation reported by a recognized, publicly available source as being the median of expectations contributed by broker-dealers or other entities, except insurers, engaged in the business of selling or evaluating such securities or assets. The prepayment expectation used in this calculation shall be, at the insurer's election, the prepayment expectation for pass-through securities of the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation, the Government National Mortgage Association, or for other assets of the same type as the assets that underlie the asset-backed security, in either case which has a gross weighted average coupon comparable to the gross weighted average coupon of the assets that underlie the asset-backed security; or

(bb) Another prepayment threshold assumption specified by the Commissioner by regulation promulgated under § 31-1375.01.

(ii) For the purposes of this subparagraph, if the asset-backed security is purchased in combination with one or more other asset-backed securities that are supported by identical underlying collateral, the insurer may calculate the rate of return for these specific combined asset-backed securities in combination; provided, that the insurer shall maintain documentation demonstrating that the securities were acquired and are continuing to be held in combination.

(83) “State” means any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of Northern Mariana Islands.

(84) “Substantially similar securities” means securities that meet all criteria for substantially similar specified in the NAIC Accounting Practices and Procedures Manual, and in an amount that constitutes good delivery form as determined from time to time by the Public Securities Administration.

(85) “SVO” means the Securities Valuation Office of the NAIC, or any successor office established by the NAIC.

(86) “Swap” means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests.

(87) “Variable contracts” means a variable annuity or a variable life insurance policy.

(88) “Underlying interest” means the assets, liabilities, other interests or a combination thereof underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities, or derivative instruments.

(89) “Unrestricted surplus” means the amount by which total admitted assets exceed 125% of the insurer’s required liabilities.

(90) “Warrant” means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities or to facilitate divestiture of the securities of another business entity.

(Apr. 11, 2003, D.C. Law 14-297, § 102, 50 DCR 330; July 2, 2011, D.C. Law 18-378, § 3(v), 58 DCR 1720.)

Effect of amendments. — D.C. Law 18-378, in par. (51), substituted “Chapter 8 of Title 29” for “Chapter 10 of Title 29”.

Legislative history of Law 18-378. — For history of Law 18-378, see notes under § 31-754.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1371.03. General investment qualifications.

(a) Domestic insurers may acquire, hold, or invest in investments or engage in investment practices as set forth in this chapter. In addition to investments conforming to this act, domestic insurers may also invest in securities of one or more subsidiaries of the insurer to the extent permitted by § 31-702.

(b) Subject to subsection (c) of this section, an insurer shall not acquire or hold an investment as an admitted asset unless, at the time of acquisition, it is:

(1) Eligible for the payment or accrual of interest or discount, whether in cash or other securities; eligible to receive dividends or other distributions; or is otherwise income-producing; or

(2) Acquired under §§ 31-1372.07(c), 31-1372.08, 31-1372.10, 31-1372.12, 31-1373.08(c), 31-1373.09, 31-1373.11, or 31-1373.12, or under other provisions of District of Columbia law other than this chapter.

(c) An insurer may acquire or hold as admitted assets investments that do not otherwise qualify as provided in this chapter if the insurer has not acquired them for the purpose of circumventing any limitations contained in this chapter, the insurer complies with the provisions of §§ 31-1371.04 and 31-1371.06 as to the investments, and the insurer acquires the investments in the following circumstances:

(1) As payment on account of existing indebtedness or in connection with the refinancing, restructuring, or workout of existing indebtedness, if taken to protect the insurer's interest in that investment;

(2) As realization on collateral for an obligation;

(3) In connection with an otherwise qualified investment or investment practice, (A) as interest on or a dividend or other distribution related to the investment or investment practice or in connection with the refinancing of the investment, and (B) for no additional or only nominal consideration;

(4) Under a lawful and bona fide agreement of recapitalization or voluntary or involuntary reorganization in connection with an investment held by the insurer; or

(5) Under a bulk reinsurance, merger, or consolidation transaction approved by the Commissioner if the assets constitute admissible investments for the ceding, merged, or consolidated companies.

(d) Unless within the period the investment has become a qualified investment under a section of this chapter other than subsection (c) of this section, an investment, or portion of an investment, acquired by an insurer under subsection (c) of this section shall become a nonadmitted asset 3 years (or 5 years in the case of mortgage loans and real estate) from the date of its acquisition; provided, that an investment acquired under an agreement of bulk reinsurance, merger, or consolidation may be qualified for a long period if so provided in the plan for reinsurance, merger, or consolidation as approved by the Commissioner. Upon application by the insurer and a showing that the nonadmission of an asset held under subsection (c) of this section would materially injure the interests of the insurer, the Commissioner may extend the period for admissibility for an additional reasonable period of time.

(e) Except as provided in subsections (f) and (h) of this section, an investment shall qualify under this chapter if, on the date that the insurer committed to acquire the investment or on the date of its acquisition, it would have qualified under this chapter. For the purposes of determining limitations contained in this chapter, an insurer shall give appropriate recognition to any commitments to acquire investments.

(f)(1) An investment held as an admitted asset by an insurer on April 11, 2003, which qualified under § 31-4435 [repealed], and § 31-2502.18 [repealed], shall remain qualified as an admitted asset under this chapter.

(2) Each specific transaction constituting an investment practice of the type described in this chapter that was lawfully entered into by an insurer and was in effect on April 11, 2003, shall continue to be permitted under this chapter until its expiration or termination under its terms.

(g) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the

amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the Commissioner. For purposes of computing any limitation based upon admitted assets, the insurer shall deduct from the amount of its admitted assets the amount of the liability recorded on its statutory balance sheet for:

(1) The return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

(2) Cash received in a dollar roll transaction; and

(3) The amount reported as borrowed money in the most recently filed financial statement to the extent not included in paragraphs (1) and (2) of this subsection.

(h) An investment qualified, in whole or in part, for acquisition or holding as an admitted asset may be qualified or requalified at the time of acquisition or a later date, in whole or in part, under any other section, if the relevant conditions contained in the other section are satisfied at the time of qualification or requalification.

(i) An insurer shall maintain documentation demonstrating that investments were acquired in accordance with this chapter and specifying the section of this chapter under which they were acquired.

(j) An insurer shall not enter into an agreement to purchase securities in advance of their issuance for resale to the public as part of a distribution of the securities by the issuer or otherwise guarantee the distribution, except that an insurer may acquire privately placed securities with registration rights.

(k) Notwithstanding any provision of this chapter, the Commissioner may, by rule or order, permit an insurer to nonadmit, limit, dispose of, withdraw from, or discontinue an investment or investment practice to the extent the Commissioner finds that the investment or investment practice endangers the solvency of the insurer or is otherwise hazardous to policyholders, creditors, or the public in the District of Columbia. The authority of the Commissioner under this subsection shall be in addition to any other authority of the Commissioner.

(l) Insurance future and insurance futures options shall not be considered investments or investment practices for purposes of this chapter.

(Apr. 11, 2003, D.C. Law 14-297, § 103, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1371.04. Authorization of investments by the board of directors.

(a) An insurer's board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity, and diversification of investments and other specifications, including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus. The board of directors shall review and assess the insurer's technical

investment and administrative capabilities and expertise before adopting a written plan concerning an investment strategy or investment practice.

(b) Investments acquired and held under this chapter shall be acquired and held under the supervision and direction of the board of directors of the insurer. The board of directors shall evidence by formal resolution, at least annually, that it has determined whether all investments have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board of directors or a committee of the board of directors charged with the responsibility to direct its investments.

(c) On no less than a quarterly basis, and more often if considered appropriate, an insurer's board of directors, or committee of the board of directors, shall:

(1) Receive and review a summary report on the insurer's investment portfolio, its investment activities, and investment practices engaged in under delegated authority, to determine whether the investment activity of the insurer is consistent with its written plan; and

(2) Review and revise, as appropriate, the written plan.

(d) In discharging its duties under this section, the board of directors shall require that records of an authorization or approval, other documentation as the board of directors may require, and the report of an action taken under authority delegated under the plan referred to in subsection (a) of this section shall be made available on a regular basis to the board of directors.

(e) In discharging their duties under this section, the directors of an insurer shall perform their duties in good faith and with that degree of care that ordinarily prudent individuals in like positions would use under similar circumstances.

(f) If an insurer does not have a board of directors, all references to the board of directors in this chapter shall refer to the governing body of the insurer having authority equivalent to that of a board of directors.

(Apr. 11, 2003, D.C. Law 14-297, § 104, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1371.05. Prohibited investments.

(a) An insurer shall not, directly or indirectly:

(1) Invest in an obligation or security or make a guarantee for the benefit of or in favor of an officer or director of the insurer, except as provided in § 31-1371.06;

(2) Invest in an obligation or security, make a guarantee for the benefit of or in favor of, or make other investments in a business entity of which 10% or more of the voting securities or equity interests are owned, directly or indirectly, by or for the benefit of one or more officers or directors of the insurer, except as authorized in § 31-701, or provided in § 31-1371.06;

(3) Engage on its own behalf or through one or more affiliates in a transaction or series of transactions designed to evade the prohibitions of this chapter;

(4) Invest in a partnership as a general partner; provided, that an insurer may make an investment as a general partner:

(A) If all other partners in the partnership are subsidiaries of the insurer;

(B) For the purpose of:

(i) Meeting cash calls committed to prior to April 11, 2003;

(ii) Completing those specific projects or activities of the partnership in which the insurer was a general partner as of April 11, 2003, that had been undertaken as of that date; or

(iii) Making capital improvements to property owned by the partnership on April 11, 2003, if the insurer was a general partner as of that date; or

(C) In accordance with § 31-1371.03(c); or

(5) Invest in or lend its funds upon the security of shares of its own stock, except that an insurer may acquire shares of its own stock, which shall not be admitted assets of the insurer for the following purposes:

(A) Conversion of a stock insurer into a mutual or reciprocal insurer or a mutual or reciprocal insurer into a stock insurer;

(B) Issuance to the insurer's officers, employees, or agents in connection with a plan approved by the Commissioner for converting a publicly-held insurer into a privately-held insurer under § 31-903, or in connection with other stock option and employee benefit plans; or

(C) In accordance with any other plan approved by the Commissioner.

(b) Subsection (a)(3) of this section shall not prohibit a subsidiary or other affiliate of the insurer from becoming a general partner.

(Apr. 11, 2003, D.C. Law 14-297, § 105, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1371.06. Loans to officers and directors.

(a) Except as provided in subsection (b) of this section, an insurer shall not, without the prior written approval of the Commissioner, directly or indirectly:

(1) Make a loan to or other investment in an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest;

(2) Make a guarantee for the benefit of or in favor of an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest; or

(3) Enter into an agreement for the purchase or sale of property from or to an officer to director of the insurer or a person in which the officer or director has any direct or indirect financial interest.

(b)(1) For purposes of this section, an officer or director shall not be deemed to have a financial interest by reason of:

(A) An interest that is held directly or indirectly through the ownership of equity interests representing less than 2% of all outstanding equity interests issued by a person that is a party to the transaction; or

(B) The individual's position as a director or officer of a person that is a party to the transaction.

(2) Paragraph (1) of this subsection shall not:

(A) Permit an investment that is prohibited by § 31-1371.05; or

(B) Apply to a transaction between an insurer and any of its subsidiaries or affiliates that is entered into in connection with § 31-701, other than a transaction between an insurer and its officer or director.

(c) An insurer may make, without the prior written approval of the Commissioner:

(1) Policy loans in accordance with the terms of the policy or contract and § 31-1372.11;

(2) Advances to officers or directors for expenses reasonably expected to be incurred in the ordinary course of the insurer's business or guarantees associated with credit or charge cards issued or credit extended for the purpose of financing these expenses;

(3) Loans secured by the principal residence of an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans comply with the requirements of § 31-1372.07 or § 31-1372.08 and the terms and conditions otherwise are the same as those generally available from unaffiliated third parties;

(4) Secured loans to an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request, if the loans:

(A) Do not have a term exceeding 2 years;

(B) Are required to finance mortgage loans outstanding at the same time on the prior and new residences of the officer;

(C) Do not exceed an amount equal to the equity of the officer in the prior residence; and

(D) Are required to be fully repaid upon the earlier of the end of the 2-year period or the sale of the prior residence; or

(5) Loans and advances to officers or directors made in compliance with state or federal law specifically related to the loans and advances by a regulated non-insurance subsidiary or affiliate of the insurer in the ordinary course of business and on terms no more favorable than available to other customers of the entity.

(Apr. 11, 2003, D.C. Law 14-297, § 106, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1371.07. Valuation of investments.

For the purposes of this chapter, the value or amount of an investment acquired or held, or any investment practice engaged in, under this chapter, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the NAIC, including the *Purposes and Procedures of the Securities Valuation Office*, the *Valuation of Securities*, the *Accounting*

Practices and Procedures, the Annual Statement Instructions, or any successor valuation procedures officially adopted by the NAIC.

(Apr. 11, 2003, D.C. Law 14-297, § 107, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Subchapter II. Life Insurers.

§ 31-1372.01. Application of subchapter.

This subchapter shall apply to the investments and investment practices of life insurers subject to the provisions of this chapter pursuant to § 31-1371.01.

(Apr. 11, 2003, D.C. Law 14-297, § 201, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.02. General 3% diversification, medium and lower grade investments, and Canadian investments.

(a)(1) Except as otherwise specified in this chapter, an insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under this chapter if, as a result of and other giving effect to the investment, the insurer would hold more than 3% of its admitted assets in investments of all kinds issued, assumed, accepted, insured, or guaranteed by a single person.

(2) The 3% limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of paragraph (1) of this subsection; provided, that an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity held by the insurer would exceed 3% of its admitted assets.

(b)(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under §§ 31-1372.03, 31-1372.06, or 31-1372.09, or counterparty exposure under § 31-1372.10(d) if, as a result of and after giving effect to the investment:

(A) The aggregate amount of medium and lower grade investments then held by the insurer would exceed 20% of its admitted assets;

(B) The aggregate amount of lower grade investments then held by the insurer would exceed 10% of its admitted assets;

(C) The aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed 3% of its admitted assets;

(D) The aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed one percent of its admitted assets; or

(E) The aggregate amount of medium and lower grade investments held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life would exceed one percent of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under § 31-1372.03, § 31-1372.06, or § 31-1372.09, or counterparty exposure under § 31-1372.10(d) if, as a result of and after giving effect to the investment:

(A) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities, secured by or evidencing an interest in a single asset or pool of assets held by the insurer would exceed one percent of its admitted assets; or

(B) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed 0.5% of its admitted assets.

(3) If an insurer attains or exceeds the limit of any rating category referred to in this subsection, the insurer shall not be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

(c)(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, a Canadian investment authorized by this chapter if, as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed 40% of its admitted assets or if the aggregate amount of Canadian investments not acquired under § 31-1372.03(b) held by the insurer would exceed 25% of its admitted assets.

(2) For an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of paragraph (1) of this subsection shall be increased by the greater of:

(A) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(B) One hundred fifteen percent of the amount of its reserves and other obligations under contracts on lives or risks resident or located in Canada.

(Apr. 11, 2003, D.C. Law 14-297, § 202, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.03. Rated credit instruments.

(a) Subject to the limitations of § 31-1372.02(b) and subsection (f) of this section, but not to the limitations of § 31-1372.02(a), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(1) The United States; or

(2) A government-sponsored enterprise of the United States if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

(b)(1) Subject to the limitations of § 31-1372.02(b) and paragraph (2) of this subsection, but not the limitations of § 31-1372.02(a), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(A) Canada; or

(B) A government-sponsored enterprise of Canada if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada.

(2) An insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection would exceed 40% of its admitted assets.

(c)(1) Subject to the limitations of § 31-1372.02(b) and paragraph (2) of this subsection, but not to the limitations of § 31-1372.02(a), an insurer may acquire rated credit instruments, excluding asset-backed securities:

(A) Issued by a government money market mutual fund, a class one money market mutual fund, or a class one bond mutual fund;

(B) Issued, assumed, guaranteed, or insured by a government-sponsored enterprise of the United States other than those eligible under subsection (a) of this section;

(C) Issued, assumed, guaranteed, or insured by a state if the instruments are general obligations of the state; or

(D) Issued by a multilateral development bank.

(2) An insurer shall not acquire an instrument of any fund, enterprise or entity, or state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise or entity, or state under this subsection would exceed 10% of its admitted assets.

(d) Subject to the limitations of § 31-1372.02, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(1) The aggregate amount of preferred stock then held by the insurer under this subsection does not exceed 20% of its admitted assets; and

(2) The aggregate amount of preferred stock then held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed 10% of its admitted assets.

(e) Subject to the limitations of § 31-1372.02, in addition to those investments eligible under subsections (a), (b), (c), and (d) of this section, an insurer may acquire rated credit instruments that are not foreign investments.

(f) Notwithstanding any other provision of this section, an insurer shall not acquire special rated credit instruments under this section if, as a result of and

after giving effect to the investment, the aggregate amount of special rated credit instruments held by the insurer would exceed 5% of its admitted assets.

(g) For purposes of this section, obligations of the Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, or other mortgage-backed or mortgage-related securities as defined in section 106 of the Secondary Mortgage Market Enhancement Act of 1984, approved October 3, 1984 (98 Stat. 1691; 15 U.S.C. § 77r-1), may be acquired to the same extent as allowed under subsection (a) of this section, whether or not they are rated credit instruments authorized in subsection (a) of this section.

(Apr. 11, 2003, D.C. Law 14-297, § 203, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.04. Insurer investment pools.

(a) An insurer may acquire investments in investment pools that invest only in:

(1) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(A) A remaining maturity not exceeding 397 days or a put that entitles the holder to receive the principal amount of the obligation, which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) A remaining maturity not exceeding 3 years, a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (including federal funds, prime rate, treasury bills, London InterBank Offered Rate, or commercial paper), and is subject to no maximum limit if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(2) Government money market mutual funds or class one money market mutual funds; or

(3) Securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of § 31-1372.08, except the quantitative limitations of § 31-1372.08(d); or

(4) Investments which an insurer may acquire under this chapter if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this chapter.

(b) For an investment in an investment pool to be qualified, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of § 31-1372.08 other than the quantitative limitations of § 31-1372.08(d); or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this section to exceed 10% of the total assets of the investment pool.

(c) The limitations of § 31-1372.02(a) shall not apply to an insurer's investment in an investment pool; provided, that an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments held by the insurer under this section:

(1) In any one investment pool would exceed 10% of its admitted assets;

(2) In all investment pools investing in investments permitted under subsection (a)(2) of this section, would exceed 25% of its admitted assets; or

(3) In all investment pools would exceed 35% of its admitted assets.

(d) For an investment in an investment pool to be qualified, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2)(A) Be the insurer; an affiliated insurer or a business entity affiliated with the insurer; a qualified bank; or a business entity registered under the Investment Advisors Act of 1940, approved August 22, 1984 (54 Stat. 789; 15 U.S.C. § 80a-1 et seq.);

(B) In the case of a reciprocal insurer or interinsurance exchange, be its attorney-in-fact; or

(C) In the case of a United States branch of non-U.S. insurer, be its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(A) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(B) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date, if any, and other appropriate designations); and

(C) Other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank, which custody agreement shall:

(A) State and recognize the claims and rights of each participant;

(B) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investment in the investment pool; and

(C) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

(e) The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers; in the case of an investment pool investing solely in investments permitted under subsection (a)(1) of this

section, the insurer and its subsidiaries, affiliates, or any pension or profit-sharing plan of the insurer, its subsidiaries, and affiliates; and, in the case of a United States branch of a non-U.S. insurer, the affiliates or subsidiaries of its United States manager, shall, at all times, hold 100% of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) Each participant owns an undivided interest in the underlying assets of the investment pool; and

(B) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day; provided, that settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five 5 business days.

(6) The pool manager shall make the records of the investment pool available for inspection by the Commissioner.

(f) Distributions under subsection (e)(5) of this section shall be calculated net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager may distribute to a participant, at the discretion of the pool manager:

(A) In cash, the fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) In kind, a pro rata share of each underlying asset; or

(C) In a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(Apr. 11, 2003, D.C. Law 14-297, § 204, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.05. Equity interests.

(a) Subject to the limitations of § 31-1372.02, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.

(b) An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments held by the insurer under this section would exceed 20% of its admitted assets or the amount of equity interests held by the insurer that are not listed on a qualified exchange would exceed 5% of its admitted assets. An accident and health insurer shall not be subject to this section, but shall be

subject to the same aggregate limitation on equity interests as a fire, casualty, and marine insurer under § 31-1373.06 and to the provisions of § 31-1373.02.

(c) An insurer shall not acquire under this section any investments that the insurer may acquire under § 31-1372.07.

(d) An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within 6 months of the short sale.

(Apr. 11, 2003, D.C. Law 14-297, § 205, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.06. Tangible personal property under lease.

(a)(1) Subject to the limitations of § 31-1372.02, an insurer may acquire tangible personal property or equity interests therein, which property or interests are located or used wholly or in part within a domestic jurisdiction, directly or indirectly through:

(A) Limited partnership interests and general partnership interests not otherwise prohibited § 31-1371.05;

(B) Joint ventures;

(C) Stock of an investment subsidiary;

(D) Membership interests in a limited liability company;

(E) Trust certificates; or

(F) Other similar instruments.

(2) Investments acquired under paragraph (1) of this subsection shall be eligible only if:

(A) The property is subject to a lease or other agreement with a person whose rated credit instruments the insurer could acquire under § 31-1372.03 for a price equal to the purchase price of the personal property; and

(B) The lease or other agreement provides the insurer the right to receive rental, purchase, or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be adequate to return the cost of the insurer's investment in the property, plus a return considered adequate by the insurer.

(b) The insurer shall compute the amount of each investment under this section on the basis of the cash purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses to the extent the borrowing is nonrecourse to the insurer.

(c) An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments held by the insurer under this section would exceed:

(1) Two percent of its admitted assets; or

(2) One half of one percent of its admitted assets as to any single item of tangible personal property.

(d) For purposes of determining compliance with the limitations of § 31-1372.02:

(1) Investments acquired by an insurer under this section shall be aggregated with those acquired under § 31-1372.03; and

(2) Each lessee of the property under a lease referred to in this section shall be deemed the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided under subsection (b) of this section.

(e) This section shall not be applicable to a lease of tangible personal property between an insurer and its subsidiaries or affiliates under a cost sharing arrangement or agreement permitted under subchapter I of Chapter 7 of Title 31.

(Apr. 11, 2003, D.C. Law 14-297, § 206, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.07. Mortgage loans and real estate.

(a)(1) Subject to the limitations of § 31-1372.02, an insurer may acquire, directly or indirectly, through limited partnership interests and general partnership interests not otherwise prohibited by § 31-1371.05, joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments, obligations secured by a first mortgage on real estate situated within a domestic jurisdiction; provided, that a mortgage loan which is secured by a subordinate lien may be acquired if the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority, shall not, at the time of acquisition of the obligations, exceed:

(A) Ninety percent of the fair market value of the real estate if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(B) Eighty percent of the fair market value of the real estate if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period not exceeding 30 years, and periodic payments made no less frequently than annually; provided, that:

(i) Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate, and requiring equal payments of principal and interest with the same frequency over the same amortization period;

(ii) Mortgage loans permitted under this paragraph shall be permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan; and

(iii) For residential mortgage loans, the 80% limitation shall be 97% if acceptable private mortgage insurance has been obtained; or

(C) Seventy-five percent of the fair market value of the real estate for

mortgage loans that do not meet the requirements of subparagraphs (A) or (B) of this paragraph.

(2) For purposes of paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

(3) A mortgage loan that is held by an insurer under § 31-1371.03(f) or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual, or successor publication, shall continue to qualify as a mortgage loan.

(4) Subject to the limitations of § 31-1372.02, credit lease transactions that do not qualify for investment under § 31-1372.03 shall be exempt from the provisions of paragraph (1) of this subsection if their terms are as follows:

(A) The loan balance at the end of the initial term of the lease will not exceed the original appraised value of the real estate;

(B) The lease payments equal or exceed the total debt service over the term of the loan;

(C) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO is obligated to make the lease payments;

(D) The insurer holds, or is the beneficial holder of, a first mortgage on the real estate;

(E) The expenses of the maintenance and operation of the real estate, excluding exterior repairs, structural repairs, parking, and heating, ventilation and air conditioning replacement expenses, are passed through to the tenant, or annual escrow contributions from the lease payments equal or exceed any deficiency in such expenses; and

(F) There is a perfected assignment of the rents due under the lease to, or for the benefit of, the insurer.

(b)(1) An insurer may acquire, manage, and dispose of real estate situated in a domestic jurisdiction, directly or indirectly, through limited partnership interests and general partnership interests not otherwise prohibited by § 31-1371.05, joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income-producing or intended for improvement or development for investment purposes under an existing program.

(2) The real estate may be subject to mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are nonrecourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (d)(2) and (d)(3) of this section.

(c)(1) An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the business operations, including home office,

branch office, and field office operations of the insurer, its affiliates, or subsidiaries.

(2) Real estate acquired under this subsection may include excess space for rent to others if the excess space, valued at its fair market value, would otherwise be a permitted investment under subsection (b) of this section and is so qualified by the insurer.

(3) The real estate acquired under this subsection may be subject to one or more mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are nonrecourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (d)(4) of this section.

(4) For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds. An insurer may acquire real estate used for these purposes under subsection (b) of this section.

(d)(1) An insurer shall not acquire an investment under subsection (a) of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments held by the insurer under subsection (a) of this section would exceed:

(A) One percent of its admitted assets in mortgage loans covering any one secured location;

(B) One quarter of one percent of its admitted assets in construction loans covering any one secured location; or

(C) Two percent of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under subsection (b) of this section if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments held by the insurer under subsection (b) of this section and the guarantees then outstanding would exceed:

(A) One percent of its admitted assets in one parcel or group of contiguous parcels of real estate; provided, that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds, such as hospitals, medical clinics, medical professional buildings, or other health facilities used for the purpose of providing health services; or

(B) Fifteen percent of its admitted assets in the aggregate, but not more than 5% of its admitted assets, as to properties that are to be improved or developed.

(3) An insurer shall not acquire an investment under subsection (a) or (b) of this section if, as a result of and after giving effect to the investment and any guarantees made by the insurer in connection with the investment, the aggregate amount of all investments held by the insurer under subsections (a) and (b) of this section and the guarantees then outstanding would exceed 45% of its admitted assets; provided, that an insurer may exceed this limitation by no more than 30% of its admitted assets if:

(A) This increased amount is invested only in residential mortgage loans;

(B) The insurer has not more than 10% of its admitted assets invested in mortgage loans other than residential mortgage loans;

(C) The loan-to-value ratio of each residential mortgage loan does not exceed 60% at the time the mortgage loan is qualified and the fair market value is supported by an appraisal no more than 2 years old, prepared by an independent appraiser;

(D) A single mortgage loan qualified does not exceed 0.5% of its admitted assets;

(E) The insurer receives approval from the Commissioner for a plan that is designed to result in a portfolio of residential mortgage loans that is sufficiently geographically diversified; and

(F) The insurer agrees to file annually with the Commissioner records that demonstrate that its portfolio of residential mortgage loans is geographically diversified in accordance with the plan.

(4) The limitations of § 31-1372.02 shall not apply to an insurer's acquisition of real estate under subsection (c) of this section. An insurer shall not acquire real estate under subsection (c) of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of real estate held by the insurer under subsection (c) of this section would exceed 10% of its admitted assets. With the permission of the Commissioner, additional amounts of real estate may be acquired under subsection (c) of this section.

(Apr. 11, 2003, D.C. Law 14-297, § 207, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.08. Securities lending, repurchase, reverse repurchase, and dollar roll transactions.

(a) An insurer may enter into securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the requirements of this section.

(b) The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan in § 31-1371.04(a) that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operations procedures to manage interest rate risk and counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

(c) The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one

year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty; provided, that for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer if:

- (1) The agent is a qualified business entity; and
- (2) The agreement:

(A) Requires the agent to enter into separate agreement with each counterparty that are consistent with the requirements of this section; and

(B) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

(d) Cash received in a transaction under this section shall be invested in accordance with this chapter and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. As long as the transaction remains outstanding, the insurer, its agent, or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the Commissioner:

- (1) Possession of the acceptable collateral;
- (2) A perfected security interest in the acceptable collateral; or
- (3) In the case of a jurisdiction outside of the United States, title, or rights of a secured creditor, to the acceptable collateral.

(e) The limitations of §§ 31-1372.02 and 31-1372.09 shall not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect shall be given to the insurer's future obligation to resell securities in the case of a repurchase transaction or to repurchase securities in the case of a reverse repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities loaned to, sold to, or purchased from any one business entity counterparty under this section would exceed 5% of its admitted assets; provided, that in calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned to, sold to, or purchased from all business entities under this section would exceed 40% of its admitted assets.

(f) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, at least equals 102% of the market value of the loaned securities.

(g) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, equals at least 95% of the market value of the transferred securities.

(h) In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(i) In a repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, equals at least 102% of the purchase price. Securities acquired by an insurer in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(Apr. 11, 2003, D.C. Law 14-297, § 208, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.09. Foreign investments and foreign currency exposure.

(a) Subject to the limitations of § 31-1372.02, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer is permitted to acquire under this chapter, other than of the type permitted under § 31-1372.04, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investment held by the insurer under this subsection does not exceed 20% of its admitted assets; and

(2) The aggregate amount of foreign investments held by the insurer under this subsection in a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 3% of its admitted assets as to any other foreign jurisdiction.

(b)(1) Subject to the limitations of § 31-1372.02, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (a) of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(A) The aggregate amount of investments held by the insurer under this subsection denominated in foreign currencies does not exceed 10% of its admitted assets; and

(B) The aggregate amount of investments held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 3% of its admitted assets as to any other foreign jurisdiction.

(2) For the purposes of this section, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under § 31-1372.10 and the business entity counterparty agrees under the contract to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which insulates the investment cash flow against future changes in currency exchange rates.

(c) In addition to investment permitted under subsections (a) and (b) of this section subject to the limitations of § 31-1372.02, an insurer that is authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and investments denominated in the currency of that jurisdiction; provided, that investments made under this subsection in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises shall not be subject to the limitations of § 31-1372.02 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

(1) The amount the insurer is required by the law of the foreign jurisdiction to invest in the foreign jurisdiction; or

(2) One hundred fifteen percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(d) In addition to investments permitted under subsections (a) and (b) of this section, subject to the limitations of § 31-1372.02, an insurer that is not authorized to do business in a foreign jurisdiction, but which has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction and investments denominated in the currency of that jurisdiction; provided, that investments made under this subsection in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises shall not be subject to the limitations of § 31-1372.02 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(e) Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this chapter, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises of these persons, except for those exempt under subsections (c) and (d) of this section, shall be subject to the limitations of § 31-1372.02.

(Apr. 11, 2003, D.C. Law 14-297, § 209, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.10. Derivative transactions.

(a) An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section, subject to the requirements of this section.

(b)(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the Commissioner.

(2) An insurer shall be able to demonstrate to the Commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction, or combination of the transactions, through cash flow testing or other appropriate analyses.

(c) An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 7.5% of its admitted assets;

(2) The aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3% of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5% of its admitted assets.

(d) An insurer may enter into the following types of income generation transactions if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flow for payments under the caps or floors, the face value of fixed income securities underlying a derivative instrument subject to call, and the amount of the purchase obligations under the puts, do not exceed 10% of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities if the insurer holds in its portfolio, or can immediately acquire through the exercise of options,

warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this chapter if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(4) Sales of covered caps or floors if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(e) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of § 31-1372.02.

(f) Under regulations promulgated under § 31-1375.01, the Commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of subsection (c) of this section or for other risk management purposes under regulations promulgated by the Commissioner; provided, that the replication transactions shall not be permitted for other than risk management purposes.

(Apr. 11, 2003, D.C. Law 14-297, § 210, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.11. Policy loans.

A life insurer may lend to a policyholder on the security of the cash surrender value of the policyholder's policy a sum not exceeding the legal reserve that the insurer is required to maintain on the policy.

(Apr. 11, 2003, D.C. Law 14-297, § 211, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1372.12. Additional investment authority.

(a) Solely for the purpose of acquiring investments that exceed the quantitative limitations of §§ 31-1372.02 through 31-1372.09, an insurer may acquire under this subsection an investment, or engage in investment practices, described in § 31-1372.08; provided, that an insurer shall not acquire and investment, or engage in investment practices, described in § 31-1372.08 under this subsection if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of investments held by an insurer under this subsection would exceed 3% of its admitted assets; or

(2) The aggregate amount of investments as to one limitation in §§ 31-1372.02 through 31-1372.09 held by the insurer under this subsection would exceed 1% of its admitted assets.

(b)(1) In addition to the authority provided under subsection (a) of this section, subject to paragraph (2) of this subsection, an insurer may acquire

under this subsection an investment of any kind, or engage in investment practices described in § 31-1372.08, that are not specifically prohibited by this chapter without regard to the categories, conditions, standards, or other limitations of §§ 31-1372.02 through 31-1372.09 if, as a result of and after giving effect to the transaction, the aggregate amount of investments held under this subsection would not exceed the lesser of:

- (A) Ten percent of its admitted assets; or
- (B) Seventy-five percent of its capital and surplus.

(2) An insurer shall not acquire any investment or engage in any investment practice under this subsection if, as a result of and after giving effect to the transaction, the aggregate amount of all investments in any one person held by the insurer under this subsection would exceed 3% of its admitted assets.

(c) In addition to the investments acquired under subsections (a) and (b) of this section, an insurer may acquire under this subsection an investment of any kind, or engage in investment practices described in § 31-1372.08, that are not specifically prohibited by this chapter without regard to any limitations of §§ 31-1372.02 through 31-1372.09 if:

(1) The Commissioner grants prior approval;

(2) The insurer demonstrates that its investments are being made in a prudent manner and that the additional amounts will be invested in a prudent manner; and

(3) As a result of and after giving effect to the transaction, the aggregate amount of investments held by the insurer under this subsection does not exceed the greater of:

(A) Twenty-five percent of its capital and surplus; or

(B) One hundred percent of capital and surplus, less 10% of its admitted assets.

(d) An investment prohibited under § 31-1371.05 or § 31-1372.10 or additional derivative instruments acquired under § 31-1372.10 shall not be acquired under this section.

(Apr. 11, 2003, D.C. Law 14-297, § 212, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Subchapter III. Fire, Casualty, and Marine Insurers.

§ 31-1373.01. Application of subchapter.

This subchapter shall apply to the investment and investment practices of domestic fire, casualty, and marine insurers.

(Apr. 11, 2003, D.C. Law 14-297, § 301, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.02. Reserve requirements.

(a)(1) Subject to all other limitations and requirements of this chapter, a fire, casualty, and marine insurer shall maintain an amount at least equal to 100% of adjusted loss reserves and loss adjustment expense reserves, 100% of adjusted unearned premium reserves, and 100% of statutorily required policy and contract reserves in:

(A) Cash and cash equivalents;

(B) High and medium grade investments that qualify under § 31-1373.04 or § 31-1373.05;

(C) Equity interests that qualify under § 31-1373.06 and that are traded on a qualified exchange;

(D) Investments of the type set forth in § 31-1373.10 if the investments are rated in the highest generic rating category by a nationally recognized statistical rating organization recognized by the SVO for rating foreign jurisdictions and if any foreign currency exposure is effectively hedged through the maturity date of the investments;

(E) Qualifying investments of the type set forth in subparagraphs (B), (C), or (D) of this paragraph that are acquired under § 31-1373.12;

(F) Interest and dividends receivable on qualifying investments of the type set forth in subparagraphs (A) through (E) of this paragraph; or

(G) Reinsurance recoverable on paid losses.

(2)(A) For purposes of determining the amount of assets to be maintained under this subsection, the calculation of adjusted loss reserves, loss adjustment expense reserves, adjusted unearned premium reserves, and statutorily required policy and contract reserves shall be based on the amounts reported to the Commissioner on its most recent annual or quarterly statement.

(B)(i) Adjusted loss reserves and loss adjustment expense reserves shall be calculated as follows:

(I) The losses and loss adjustment expenses reported by the insurer as unpaid for each accident year for each individual line of business ("unpaid losses"); multiplied by

(II) The discount factor that is applicable to the line of business and accident year published by the Internal Revenue Service under 26 U.S.C. § 846, for the calendar year that corresponds to the most recent annual statement of the insurer; less

(III) Accrued retrospective premiums discounted by an average discount factor, which shall be calculated by dividing the unpaid losses, discounted (as provided under sub-sub-subparagraph (II) of this sub-subparagraph), by the unpaid losses.

(ii) For purposes of these calculations, the unpaid losses shall be net of anticipated salvage and subrogation and gross of any discount for the time value of money or tabular discount.

(C) Adjusted unearned premium reserves shall be equal to:

(i) The amount reported by the insurer as unearned premium reserves; less

(ii) The admitted asset amounts reported by the insurer as:

(I) Premiums, and agents' balances, in the course of collection, accident and health premiums due and unpaid, and uncollected premiums for accident and health premiums;

(II) Premiums, agents' balances, and installments booked but deferred and not yet due; and

(III) Bills receivable taken for premium.

(D) Statutorily required policy and contract reserves shall include the amounts required by Chapter 19 of Title 31.

(b) A fire, casualty, and marine insurer shall supplement its annual statement with a reconciliation and summary of its assets and reserve requirements as required under subsection (a) of this section. A reconciliation and summary showing that an insurer's assets as required under subsection (a) of this section are at least equal to its undiscounted reserves required under subsection (a) of this section shall be sufficient to satisfy this requirement. Upon prior notification, the Commissioner may require an insurer to submit the reconciliation and summary with any quarterly statement filed during the calendar year.

(c) If a fire, casualty, and marine insurer's assets and reserves is not in compliance with subsection (a) of this section, the insurer shall notify the Commissioner immediately of the amount by which the reserve requirements exceed the annual statement value of the qualifying assets, explain why the deficiency exists, and, within 30 days of the date of the notice, propose a plan of action to remedy the deficiency.

(d)(1) If the Commissioner determines that an insurer is not in compliance with subsection (a) of this section, the Commissioner shall require the insurer to eliminate the condition causing the noncompliance within a specified time from the date that the notice of the Commissioner's requirement is mailed or delivered to the insurer.

(2) If an insurer fails to comply with the Commissioner's requirement under paragraph (1) of this subsection, the insurer shall be deemed to be in hazardous financial condition and the Commissioner shall take one or more of the actions authorized by law as to insurers in hazardous financial condition.

(Apr. 11, 2003, D.C. Law 14-297, § 302, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.03. General 5% diversification, medium and lower grade investments, and Canadian investments.

(a)(1) Except as otherwise specified in this chapter, an insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under this chapter if, as a result of and after giving effect to the investment, the insurer would hold more than 5% of its admitted assets in investments of all kinds issued, assumed, accepted, insured, or guaranteed by a single person.

(2) The 5% limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(3) Asset-backed securities shall not be subject to the limitations of paragraph (1) of this subsection; provided, that an insurer shall not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity, held by the insurer would exceed 5% of its admitted assets.

(b)(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under § 31-1373.04, § 31-1373.07, or § 31-1373.10, or counterparty exposure under § 31-1373.11(d) if, as a result of and after giving effect to the investment:

(A) The aggregate amount of all medium and lower grade investments held by the insurer would exceed 20% of its admitted assets;

(B) The aggregate amount of lower grade investments held by the insurer would exceed 10% of its admitted assets;

(C) The aggregate amount of investments rated 5 or 6 by the SVO held by the insurer would exceed 5% of its admitted assets;

(D) The aggregate amount of investments rated 6 by the SVO held by the insurer would exceed one percent of its admitted assets; or

(E) The aggregate amount of medium and lower grade investments held by the insurer that receive as cash income less than the equivalent yield for Treasury issues with a comparative average life would exceed one percent of its admitted assets.

(2) An insurer shall not acquire, directly or indirectly through an investment subsidiary, an investment under § 31-1373.04, § 31-1373.07, or § 31-1373.10, or counterparty exposure under § 31-1373.11(d) if, as a result of and after giving effect to the investment:

(A) The aggregate amount of medium and lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, held by the insurer would exceed one percent of its admitted assets; or

(B) The aggregate amount of lower grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, held by the insurer would exceed 0.5% of its admitted assets.

(3) If an insurer attains or exceeds the limit of any one rating category under this subsection, the insurer shall not be precluded from acquiring investments in other rating categories subject to the specific and multi-category limits applicable to those investments.

(c)(1) An insurer shall not acquire, directly or indirectly through an investment subsidiary, a Canadian investment authorized by this chapter if, as a result of and after giving effect to the investment:

(A) The aggregate amount of these investments held by the insurer would exceed 40% of its admitted assets; or

(B) The aggregate amount of Canadian investments not acquired under § 31-1373.04(b) held by the insurer would exceed 25% of its admitted assets.

(2) As to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of paragraph (1) of this subsection shall be increased by the greater of:

(A) The amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(B) One hundred twenty-five percent of the amount of its reserves and other obligations under contracts on risks resident or located in Canada.

(Apr. 11, 2003, D.C. Law 14-297, § 303, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.04. Rated credit instruments.

(a) Subject to the limitations of § 31-1373.03(b) and subsection (f) of this section, but not to the limitations of § 31-1373.03(a), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(1) The United States; or

(2) A government-sponsored enterprise of the United States if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

(b)(1) Subject to the limitations of § 31-1373.03(b), but not to the limitations of § 31-1373.03(a), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(A) Canada; or

(B) A government-sponsored enterprise of Canada if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada;

(2) An insurer shall not acquire an instrument under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments held by the insurer under this subsection would exceed 40% of its admitted assets.

(c)(1) Subject to the limitations of § 31-1373.03(b) and paragraph (2) of this subsection, but not to the limitations of § 31-1373.03(a), an insurer may acquire rated credit instruments, excluding asset-backed securities:

(A) Issued by a government money market mutual fund, a class one money market mutual fund, or a class one bond mutual fund;

(B) Issued, assumed, guaranteed, or insured by a government-sponsored enterprise of the United States other than those eligible under subsection (a) of this section;

(C) Issued, assumed, guaranteed, or insured by a state if the instruments are general obligations of the state; or

(D) Issued by a multilateral development bank.

(2) An insurer shall not acquire an instrument of any fund, enterprise, or entity, or state under this subsection if, as a result of and after giving effect to the investment, the aggregate amount of investments held in any one fund, enterprise or entity or state under this subsection would exceed 10% of its admitted assets.

(d) Subject to the limitations of § 31-1373.03, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(1) The aggregate amount of preferred stocks held by the insurer under this subsection does not exceed 20% of its admitted assets; and

(2) The aggregate amount of preferred stocks held by the insurer under this subsection which are not sinking fund stocks or rated P1 or P2 by the SVO does not exceed 10% of its admitted assets.

(e) Subject to the limitations of § 31-1373.03, in addition to those investments eligible under subsections (a), (b), (c), and (d) of this section, an insurer may acquire rated credit instruments that are not foreign investments.

(f) Notwithstanding any other provision of this section, an insurer shall not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments held by the insurer would exceed 5% of its admitted assets.

(g) For purposes of this section, obligations of Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, and other mortgage related securities as defined in section 106 of the Secondary Mortgage Market Enhancement Act of 1984, approved October 3, 1984 (98 Stat. 1691; 15 U.S.C. § 77r-1), may be acquired to the same extent as allowed under subsection (a) of this section, whether or not they are rated credit instruments authorized in § 31-1373.04(a).

(Apr. 11, 2003, D.C. Law 14-297, § 304, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.05. Insurer investment pools.

(a) An insurer may acquire investments in investment pools that invest only in:

(1) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally recognized statistical rating organization recognized by the SVO and have:

(A) A remaining maturity not exceeding 397 days or a put that entitles the holder to receive the principal amount of the obligation, which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) A remaining maturity not exceeding 3 years, and a floating interest rate that resets no less frequently than quarterly on the basis of a current

short-term index (including federal funds, prime rate, treasury bills, London InterBank Offered Rate, or commercial paper) and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(2) Government money market mutual funds or class one money market mutual funds; or

(3) Securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of § 31-1373.09 other than the quantitative limitations of 31-1373.09(d); or

(4) Investments which an insurer may acquire under this chapter if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this chapter.

(b) For an investment in an investment pool to be qualified under this chapter, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of § 31-1373.09 other than the quantitative limitations of § 31-1373.09(d); or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this section to exceed 10% of the total assets of the investment pool.

(c) The limitations of § 31-1373.03(a) shall not apply to an insurer's investment in an investment pool; provided, that an insurer shall not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments held by the insurer under this section:

(1) In any one investment pool would exceed 10% of its admitted assets;

(2) In all investment pools investing in investments permitted under subsection (a)(2) of this section, would exceed 25% of its admitted assets; or

(3) In all investment pools would exceed 40% of its admitted assets.

(d) For an investment in an investment pool to be qualified under this chapter, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2)(A) Be the insurer; an affiliated insurer or a business entity affiliated with the insurer; a qualified bank; a business entity registered under the Investment Advisors Act of 1940, approved August 22, 1984 (54 Stat. 789; 15 U.S.C. § 80a-1 et seq.);

(B) In the case of a reciprocal insurer or interinsurance exchange, be its attorney-in-fact; or

(C) In the case of a United States branch of a non-U.S. insurer, be its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(A) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(B) A complete description of all underlying assets of the investment pool (including amount, interest rate, maturity date, if any, and other appropriate designations); and

(C) Other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank, which custody agreement shall:

(A) State and recognize the claims and rights of each participant;

(B) Acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(C) Contain an agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

(e) The pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers; in the case of an investment pool investing solely in investments permitted under subsection (a)(1) of this section, the insurer and its subsidiaries, affiliates, or any pension or profit-sharing plan of the insurer, its subsidiaries, and affiliates; and, in the case of a United States branch of a non-U.S. insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold 100% of the interests in the investment pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) Each participant owns an undivided interest in the investment pool underlying assets; and

(B) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor-in-interest, may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day; provided, that settlement of funds shall occur within a reasonable and customary period thereafter not to exceed 5 business days; and

(6) The pool manager shall make the records of the investment pool available for inspection by the Commissioner.

(f) Distributions under subsection (e)(5) of this section shall be calculated net of all applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager may distribute to a participant, at the discretion of the pool manager:

(1) In cash, the fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(2) In kind, a pro rata share of each underlying asset; or

(3) In a combination of cash and in kind distributions, a pro rata share in each underlying asset.

(Apr. 11, 2003, D.C. Law 14-297, § 305, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.06. Equity interests.

(a) Subject to the limitations of § 31-1373.03, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.

(b) An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments held by the insurer under this section would exceed the greater of 25% of its admitted assets or 100% of its surplus as regards policyholders.

(c) An insurer shall not acquire under this section any investments that the insurer may acquire under § 31-1373.08.

(d) An insurer shall not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within 6 months of the short sale.

(Apr. 11, 2003, D.C. Law 14-297, § 306, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.07. Tangible personal property under lease.

(a)(1) Subject to the limitations of § 31-1373.03, an insurer may acquire tangible personal property or equity interests therein, which property or interests are located or used wholly or in part within a domestic jurisdiction, directly or indirectly, through:

(A) Limited partnership interests and general partnership interests not otherwise prohibited by section 31-1371.05;

(B) Joint ventures;

(C) Stock of an investment subsidiary;

(D) Membership interests in a limited liability company;

(E) Trust certificates; or

(F) Other similar instruments.

(2) Investments acquired under paragraph (1) of this subsection shall be eligible only if:

(A) The property is subject to a lease or other agreement with a person whose rated credit instruments the insurer could acquire under § 31-1373.04 for a price equal to the purchase price of the personal property; and

(B) The lease or other agreement provides the insurer the right to receive rental, purchase, or other fixed payments for the use or purchase of the property, and the aggregate value of the payments, together with the esti-

mated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, shall be at least equal to the cost of the insurer's investment in the property, plus a return considered adequate by the insurer.

(b) The insurer shall compute the amount of each investment under this section on the basis of the cash purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses to the extent the borrowing is nonrecourse to the insurer.

(c) An insurer shall not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments held by the insurer under this section would exceed:

(1) Two percent of its admitted assets; or

(2) One half of one percent of its admitted assets as to any single item of tangible personal property.

(d) For purposes of determining compliance with the limitations of § 31-1373.03:

(1) Investments acquired by an insurer under this section shall be aggregated with those acquired under § 31-1373.04; and

(2) Each lessee of the property under a lease referred to in this section shall be deemed the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided under subsection (b) of this section.

(e) This section shall not be applicable to a lease of tangible personal property between an insurer and its subsidiaries or affiliates under a cost sharing arrangement or agreement permitted under subchapter I of Chapter 7 of Title 31.

(Apr. 11, 2003, D.C. Law 14-297, § 307, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.08. Mortgage loans and real estate.

(a)(1) Subject to the limitations of § 31-1373.03, an insurer may acquire, directly or indirectly, through limited partnership interests and general partnership interests not otherwise prohibited by § 31-1371.05, joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments, obligations secured by a first mortgage on real estate situated within a domestic jurisdiction; provided, that a mortgage loan which is secured by a subordinate lien shall not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority, shall not, at the time of acquisition of the obligation, exceed:

(A) Ninety percent of the fair market value of the real estate if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(B) Eighty percent of the fair market value of the real estate if the

mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period not exceeding 30 years, periodic payments made no less frequently than annually; provided, that:

(i) Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance which would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period;

(ii) Mortgage loans permitted under this paragraph shall be permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan;

(iii) For residential mortgage loans, the 80% limitation shall be 97% if acceptable private mortgage insurance has been obtained; or

(C) Seventy-five percent of the fair market value of the real estate for mortgage loans that do not meet the requirements of subparagraphs (A) or (B) of this paragraph.

(2) For purposes of paragraph (1) of this subsection, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans Affairs, or their successors.

(3) A mortgage loan that is held by an insurer under § 31-1371.03(f) or acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual, or successor publication, shall continue to qualify as a mortgage loan.

(4) Subject to the limitations of § 31-1373.03, credit lease transactions that do not qualify for investment under § 31-1373.04 shall be exempt from the provisions of paragraph (1) of this subsection if their terms are as follows:

(A) The loan balance at the end of the initial term of the lease will not exceed the original appraised value of the real estate;

(B) The lease payments equal or exceed the total debt service over the term of the loan;

(C) A tenant or its affiliated entity whose rated credit instruments have a SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO is obligated to make the lease payments;

(D) The insurer holds, or is the beneficial holder of, a first lien mortgage on the real estate;

(E) The expenses of the maintenance and operation of the real estate, excluding exterior, structural, parking, and heating, ventilation and air conditioning replacement expenses, are passed through to the tenant, or annual escrow contributions from the lease payments equal or exceed the deficiencies in any such expense; and

(F) There is a perfected assignment of the rents due under the lease to, or for the benefit of, the insurer.

(b)(1) An insurer may acquire, manage, and dispose of real estate situated in a domestic jurisdiction, directly or indirectly, through limited partnership interests and general partnership interests not otherwise prohibited by § 31-1371.05, joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate shall be income-producing or intended for improvement or development for investment purposes under an existing program.

(2) The real estate may be subject to mortgages, liens, other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are nonrecourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (d)(2) and (d)(3) of this section.

(c)(1) An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the business operations, including home office, branch office, and field office operations of the insurer, its affiliates, or subsidiaries.

(2) Real estate acquired under this subsection may include excess space for rent to others if the excess space, valued at its fair market value, would otherwise be a permitted investment under subsection (b) of this section and is so qualified by the insurer.

(3) The real estate acquired under this subsection may be subject to one or more mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are nonrecourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (d)(4) of this section.

(4) For purposes of this subsection, business operations shall not include that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively. An insurer may acquire real estate used for these purposes under subsection (b) of this section.

(d)(1) An insurer shall not acquire an investment under subsection (a) of this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments held by the insurer under subsection (a) of this section would exceed:

(A) One percent of its admitted assets in mortgage loans covering any one secured location;

(B) One quarter of one percent of its admitted assets in construction loans covering any one secured location; or

(C) One percent of its admitted assets in construction loans in the aggregate.

(2) An insurer shall not acquire an investment under subsection (b) of this section if, as a result of and after giving effect to the investment and any

outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments held by the insurer under subsection (b) of this section plus the guarantees then outstanding would exceed:

(A) One percent of its admitted assets in one parcel or group of contiguous parcels of real estate; provided, that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively, such as hospitals, medical clinics, medical professional buildings, or other health facilities used for the purpose of providing health services; or

(B) The lesser of 10% of its admitted assets or 40% of its surplus as regards policyholders in the aggregate as to properties that are to be improved or developed; provided, that for an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively, this limitation shall be increased to 15% of its admitted assets in the aggregate.

(3) An insurer shall not acquire an investment under subsection (a) or (b) of this section if, as a result of and after giving effect to the investment and any guarantees it has made in connection with the investment, the aggregate amount of all investments held by the insurer under subsections (a) and (b) of this section, and the guarantees then outstanding would exceed 25% of its admitted assets.

(4) The limitations of § 31-1373.03 shall not apply to an insurer's acquisition of real estate under subsection (c) of this section. An insurer shall not acquire real estate under subsection (c) of this section if, as a result of and after giving effect to the acquisition, the aggregate amount of all real estate held by the insurer under subsection (c) of this section would exceed 10% of its admitted assets. With the permission of the Commissioner, additional amounts of real estate may be acquired under subsection (c) of this section.

(Apr. 11, 2003, D.C. Law 14-297, § 308, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.09. Securities lending, repurchase, reverse repurchase and dollar roll transactions.

(a) An insurer may enter into securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the requirements of this section.

(b) The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan in § 31-1371.04(a) that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk and counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions.

(c) The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty; provided, that for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer if:

(1) The agent is a qualified business entity;

(2) The agreement:

(A) Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(B) Prohibits securities lending transactions under the agreement with the agent or its affiliates.

(d) Cash received in a transaction under this section shall be invested in accordance with this chapter and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. As long as the transaction remains outstanding, the insurer, its agent, or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company, or other securities depositories approved by the Commissioner:

(1) Possession of the acceptable collateral;

(2) A perfected security interest in the acceptable collateral; or

(3) In the case of a jurisdiction outside of the United States, title, or rights of a secured creditor, to the acceptable collateral.

(e) The limitations of §§ 31-1373.03 and 31-1373.10 shall not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection, no effect shall be given to the insurer's future obligation to resell securities in the case of a repurchase transaction or to repurchase securities in the case of a reverse repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities loaned to, sold to, or purchased from any one business entity counterparty under this section would exceed 5% of its admitted assets; provided, that in calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

(2) The aggregate amount of all securities then loaned to, sold to, or purchased from all business entities under this section would exceed 40% of its

admitted assets; provided, that the limitation of this subsection shall not apply to reverse repurchase transactions if the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and subject to a plan approved by the Commissioner.

(f) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, at least equals 102% of the market value of the loaned securities.

(g) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, equals at least 95% of the market value of the transferred securities.

(h) In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(i) In a repurchase transaction, the insurer shall receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral held in connection with the transaction, equals at least 102% of the purchase price. Securities acquired by an insurer in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(Apr. 11, 2003, D.C. Law 14-297, § 309, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.10. Foreign investments and foreign currency exposure.

(a) Subject to the limitations of § 31-1373.03, an insurer may acquire foreign investments, or engage in investment practices with persons of or in foreign jurisdictions, of substantially the same types as those that an insurer

is permitted to acquire under this chapter, other than of the type permitted under § 31-1373.05, if, as a result and after giving effect to the investment:

(1) The aggregate amount of foreign investments held by the insurer under this subsection does not exceed 20% of its admitted assets; and

(2) The aggregate amount of foreign investments held by the insurer under this subsection in a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 5% of its admitted assets as to any other foreign jurisdiction.

(b)(1) Subject to the limitations of § 31-1373.03, an insurer may acquire investments, or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (a) of this section, or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if:

(A) The aggregate amount of investments held by the insurer under this subsection denominated in foreign currencies does not exceed 15% of its admitted assets; and

(B) The aggregate amount of investments held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed 10% of its admitted as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 5% of its admitted assets as to any other foreign jurisdiction.

(2) For the purposes of this subsection, an investment shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under § 31-1373.11 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate which insulates the investment cash flow against future changes in currency exchange rates.

(c) In addition to investments permitted under subsections (a) and (b) of this section, subject to the limitations of § 31-1373.03, an insurer that is authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction, may acquire foreign investments respecting that foreign jurisdiction and investments denominated in the currency of that jurisdiction; provided, that investments made under this subsection in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises shall not be subject to the limitations of § 31-1373.03 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed the greater of:

(1) The amount the insurer is required by law to invest in the foreign jurisdiction; or

(2) One hundred twenty-five percent of the amount of its reserves, net of reinsurance, and other obligations under the contracts.

(d) In addition to investments permitted under subsections (a) and (b) of this section, subject to the limitations set forth in § 31-1373.03, an insurer

that is not authorized to do business in a foreign jurisdiction but which has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in a foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and investments denominated in the currency of that jurisdiction; provided, that investments made under this subsection in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises shall not be subject to the limitations of § 31-1373.03 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection shall not exceed 105% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on risks resident or located in the foreign jurisdiction.

(e) Investments acquired under this section shall be aggregated with investments of the same types made under all other sections of this chapter, and in a similar manner, for purposes of determining compliance with the limitations, if any, contained in the other sections. Investments in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises of these persons, except for those exempt under subsections (c) and (d) of this section, shall be subject to the limitations of § 31-1373.03.

(Apr. 11, 2003, D.C. Law 14-297, § 310, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.11. Derivative transactions.

(a) An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section, subject to the requirements of this section.

(b)(1) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions, as these terms may be further defined in regulations promulgated by the Commissioner.

(2) An insurer shall be able to demonstrate to the Commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction, or combination of transactions, through cash flow testing or other appropriate analyses.

(c) An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(1) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 7.5% of its admitted assets;

(2) The aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3% of its admitted assets; and

(3) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5% of its admitted assets.

(d) An insurer may enter into the following types of income generation

transactions if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call, the face value of fixed income securities underlying a derivative instrument subject to call, and the amount of the purchase obligations under the puts, do not exceed 10% of its admitted assets:

(1) Sales of covered call options on non-callable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed income securities;

(2) Sales of covered call options on equity securities if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold; or

(3) Sales of covered puts on investments that the insurer is permitted to acquire under this chapter if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold.

(e) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of § 31-1373.03.

(f) Under regulations promulgated under § 31-1375.01, the Commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of subsection (c) of this section or for other risk management purposes under regulations promulgated by the Commissioner; provided, that replication transactions shall not be permitted for other than risk management purposes.

(Apr. 11, 2003, D.C. Law 14-297, § 311, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-1373.12. Additional investment authority.

(a) An insurer may acquire under this section investments, or engage in investment practices, of any kind that are not specifically prohibited by this chapter or engage in investment practices without regard to any limitation in §§ 31-1373.03 through 31-1373.10; provided, that an insurer shall not acquire an investment or engage in an investment practice under this section if, as a result of and after giving effect to the transaction, the aggregate amount of the investments held by the insurer under this section would exceed the greater of:

(1) Its unrestricted surplus; or

(2) The lesser of:

(A) Ten percent of its admitted assets; or

(B) Fifty percent of its surplus as regards policyholders.

(b) An insurer shall not acquire any investment or engage in any investment practice under subsection (a)(2) of this section if, as a result of and after giving effect to the transaction the aggregate amount of all investments in any

one person held by the insurer under that subsection would exceed 5% of its admitted assets.

(Apr. 11, 2003, D.C. Law 14-297, § 312, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Subchapter IV. [Reserved].

§ 31-1374.01. **[Reserved].**

Subchapter V. Regulations.

§ 31-1375.01. **Regulations.**

The Commissioner may, in accordance with § 2-505, promulgate rules and regulations to carry out the purposes of this chapter.

(Apr. 11, 2003, D.C. Law 14-297, § 501, 50 DCR 330.)

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

CHAPTER 13B. INTERSTATE INSURANCE PRODUCT REGULATION COMPACTS.

Sec. 31-1391. Authority to enter into Interstate Insurance Product Regulation Compact.

§ 31-1391. Authority to enter into Interstate Insurance Product Regulation Compact.

(a) *In general.* — The District of Columbia is authorized to enter into an interstate compact to establish a joint state commission as an instrumentality of the District of Columbia for the purpose of establishing uniform insurance product regulations among the participating States.

(b) *Delegation.* — Any insurance product regulation compact that the Council of the District of Columbia authorizes the Mayor to execute on behalf of the District may contain provisions that delegate the requisite power and authority to the joint State commission to achieve the purposes for which the interstate compact is established.

(Oct. 16, 2006, 120 Stat. 2023, Pub. L. 109-356, § 104.)

CHAPTER 14. LAW ON EXAMINATIONS.

Sec.

31-1401. Definitions.

31-1402. Authority, scope, and scheduling of examinations.

31-1403. Conduct of examinations.

Sec.

31-1404. Examination reports.

31-1405. Conflict of interest.

31-1406. Cost of examinations.

31-1407. Immunity from liability.

§ 31-1401. Definitions.

For the purposes of this chapter, the term:

(1) Repealed.

(2) "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the insurance laws of the District of Columbia, including fraternal benefit associations and excluding the District of Columbia Life and Health Guaranty Association and the District of Columbia Property and Liability Insurance Guaranty Association.

(2A) "Department" means the Department of Insurance, Securities, and Banking.

(3) "District" means the District of Columbia.

(4) "Examiner" means any individual or firm having been authorized by the Mayor to conduct an examination under this chapter.

(5) "Person" means any individual, aggregation of individuals, trust, association, partnership, or corporation, or any affiliate thereof.

(Oct. 21, 1993, D.C. Law 10-49, § 2, 40 DCR 6110; May 21, 1997, D.C. Law 11-268, § 10(ff)(1), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 39, 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(j), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-3601.

Effect of amendments. — D.C. Law 15-166, in par. (2A), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(j) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-49. — Law 10-49, the "Law on Examinations Act of 1993," was introduced in Council and assigned Bill No. 10-131, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-94 and transmitted to both Houses of Congress for its review. D.C. Law 10-49 became effective on October 21, 1993.

Legislative history of Law 11-268. — Law

11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-49, the Law on Examinations Act of 1993, see Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

Editor's notes. — Mayor authorized to issue

rules: Section 10 of D.C. Law 10-49 provided that the Mayor shall, pursuant to subchapter I of Chapter 15 of Title 1 subchapter I of Chapter 5 of Title 2, 2001 Ed., issue rules to implement the provisions of this chapter.

§ 31-1402. Authority, scope, and scheduling of examinations.

(a) The Mayor, or any of his or her examiners, may conduct an examination under this chapter of any company as often as the Mayor in his or her sole discretion deems appropriate, but shall at a minimum conduct an examination of every insurer licensed in the District at least once every 5 years. In scheduling and determining the nature, scope, and frequency of the examinations, the Mayor shall consider such factors as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the Mayor exercises discretion under this section.

(b) For purposes of completing an examination of any company under this chapter, the Mayor may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the Mayor, necessary or material to the examination of the company.

(c) In lieu of an examination under this chapter of any foreign or alien insurer licensed in the District, the Mayor may accept, until January 1, 1994, an examination report on the company prepared by the insurance department for the company's state of domicile or port-of-entry state. Thereafter, these reports may be accepted only if the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program, or the examination is performed under the supervision of an accredited state insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department, and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(Oct. 21, 1993, D.C. Law 10-49, § 3, 40 DCR 6110.)

Prior Codifications. — 1981 Ed., § 35-3602.

Legislative history of Law 10-49. — For

legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-1401.

§ 31-1403. Conduct of examinations.

(a) Upon determining that an examination should be conducted, the Mayor shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the exami-

nation. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The Mayor may also employ any other guidelines or procedures the Mayor deems appropriate.

(b) Every company or person from whom information is sought, or its officers, directors, and agents, must provide to the examiners appointed under subsection (a) of this section, at all reasonable hours at its offices, convenient and free access to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the insurance laws of the District. Any proceedings for suspension, revocation, or nonrenewal of any license or authority shall be conducted pursuant to §§ 31-4305 and 31-2502.03.

(c) The Mayor, or any of his or her examiners, may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the Mayor may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(d) When making an examination under this chapter, the Mayor may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

(e) Nothing contained in this chapter shall be construed to limit the Mayor's authority to terminate, suspend, or complete any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of the District. Findings of fact and conclusions of law made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(f) Nothing contained in this chapter shall be construed to limit the Mayor's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Mayor may, in his or her sole discretion, deem appropriate.

(g)(1) Any insurer, agent, or broker may cause its accounts, records, documents, and files described in subsection (b) of this section to be created, recorded, copied, or reproduced by any photographic, photostatic, microfilm, microcard, miniature photographic, optical disk, electronic imaging, electronic data processing, electronically transmitted facsimile, printout, or reproduction of electronically stored data or other process which accurately reproduces or

forms a durable medium for the reproduction of an account, record, document, or file.

(2) If the items so stored are not the original but accurately represent the original, the original may be destroyed unless held in a custodial or fiduciary capacity, but only if the data is easily accessible to the department in readable form and readable reproduced copies are obtainable.

(3) A record so stored and accurately reproduced is admissible in evidence as the original in any judicial or administrative proceeding whether the original is in existence or not. The introduction of a reproduced record does not preclude admission of the original. This shall not be construed to exclude from evidence any document or copy thereof which is otherwise admissible under the rules of evidence.

(Oct. 21, 1993, D.C. Law 10-49, § 4, 40 DCR 6110; Apr. 26, 1994, D.C. Law 10-103, § 10, 41 DCR 1005; Apr. 9, 1997, D.C. Law 11-225, § 2, 44 DCR 122.)

Prior Codifications. — 1981 Ed., § 35-3603.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 10 of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-49. — For legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-1401.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and Feb-

ruary 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 11-225. — Law 11-225, the "Insurers' Records Access and Control Amendment Act of 1996," was introduced in Council and assigned Bill No. 11-605, which was referred to the Committee Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 1, 1996, and November 7, 1996, respectively. Signed by the Mayor on November 27, 1996, it was assigned Act No. 11-452 and transmitted to both Houses of Congress for its review. D.C. Law 11-225 became effective on April 9, 1997.

§ 31-1404. Examination reports.

(a) *General description.* — All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and those conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) *Filing of examination report.* — No later than 60 days following completion of the examination, the examiner in charge shall file with the Mayor a verified written report of examination under oath. Upon receipt of the verified report, the Mayor shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) *Adoption of report on examination.* — Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the Mayor shall fully consider and review the report, together with any written submis-

sions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(1) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the Mayor, the Mayor may order the company to take any action the Mayor considers necessary and appropriate to cure the violation;

(2) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refiling pursuant to subsections (a) and (b) of this section; or

(3) Calling for an investigatory hearing with no less than 20 days notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(d) *Orders and procedures.* —

(1) All orders entered pursuant to subsection (c)(1) of this section shall be accompanied by findings of fact and conclusions of law resulting from the Mayor's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. These orders shall be considered final administrative decisions and may be appealed to the Mayor pursuant to §§ 31-4332 and 31-2502.43 [repealed], and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) Any hearing conducted under subsection (c)(3) of this section by the Mayor shall be conducted as a nonadversarial confidential investigatory proceeding necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Mayor's review of relevant workpapers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of such a hearing, the Mayor shall enter an order pursuant to subsection (c)(1) of this section.

(A) The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers which tend to substantiate any assertions set forth in any written submission or rebuttal. The Mayor may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the Department, the company, or other persons. The documents produced shall be included in the record, and testimony taken by the Mayor shall be under oath and preserved for the record. Nothing contained in this section shall require the Department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(B) The hearing shall proceed with the Mayor posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. Cross examination shall be

conducted only by the Mayor. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

(e) *Publication and use.* —

(1) Upon the adoption of the examination report under subsection (c)(1) of this section, the Mayor shall continue to hold the content of the examination report as private and confidential information for a period of 10 days, except to the extent provided in subsection (b) of this section. Thereafter, the Mayor may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(2) No District law shall prevent or be construed as prohibiting the Mayor from disclosing the content of an examination report, preliminary examination report, or results, or any related matter, to the Department or the department of insurance of any other state or country, or to law enforcement officials of the District or any other state or any agency of the federal government at any time, so long as the agency or office receiving the report or related matters agrees in writing to hold it confidential in a manner consistent with this chapter.

(3) In the event the Mayor determines that regulatory action is appropriate as a result of any examination, the Mayor may initiate any proceedings or actions as provided by the laws of the District.

(f) *Confidentiality of ancillary information.* — All working papers, recorded information, documents, and copies produced by, created by, obtained by, or disclosed to the Mayor or any other person in the course of an examination made under this chapter or in the course of analysis by the Commissioner of the financial condition or market conduct of a company shall be confidential and privileged; shall not be subject to subchapter II of Chapter 5 of Title 2; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in a private civil action. The Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. Documents, materials, or other information, including all working papers, and copies, in the possession or control of the National Association of Insurance Commissioners, including its affiliates and subsidiaries, shall be confidential and privileged; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in a private civil action, if they are:

(1) Created, produced, or obtained by, or disclosed to, the National Association of Insurance Commissioners, including its affiliates and subsidiaries, while the National Association of Insurance Commissioners, including its affiliates and subsidiaries, are (A) assisting in an examination made under this chapter or an examination made by another jurisdiction with a law that is substantially similar to this chapter, or (B) assisting the Commissioner or the chief insurance regulatory official of another jurisdiction in the analysis of the financial condition or market conduct of a company; or

(2) Disclosed to the National Association of Insurance Commissioners, including its affiliates and subsidiaries, under subsection (f-2) of this section by the chief insurance regulatory official of another jurisdiction.

(f-1) The Commissioner or any person who received documents, material, or other information while acting under the authority of the Commissioner,

including the National Association of Insurance Commissioners, including its affiliates and subsidiaries, shall not be permitted to testify in a private civil action concerning confidential documents, materials, or other information subject to subsection (f) of this section.

(f-2) To assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including confidential and privileged documents, materials, or other information subject to subsection (f) of this section, with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners, including its affiliates and subsidiaries; and with state, federal and international law enforcement authorities; provided, that the recipient agrees, and has the legal authority, to maintain the confidentiality and privileged status of the documents, materials, communication, or other information;

(2) May receive documents, materials, communications, or other information, including otherwise confidential and privileged documents, materials, or other information, from the National Association of Insurance Commissioners, including its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; or

(3) May enter into agreements governing the sharing and use of information consistent with this subsection.

(f-3) No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this section or of sharing as authorized in subsection (f-2) of this section. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(f-4) A privilege established under the law of a state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, the District.

(f-5) In this section, the terms "Department," "insurance department," "law enforcement agency," "regulatory agency," and "National Association of Insurance Commissioners" shall include their employees, agents, consultants, and contractors.

(Oct. 21, 1993, D.C. Law 10-49, § 5, 40 DCR 6110; Feb. 27, 1996, D.C. Law 11-90, § 7, 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(ff)(2), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-191, § 5, 47 DCR 7311.)

Prior Codifications. — 1981 Ed., § 35-3604.

Effect of amendments. — D.C. Law 13-191 rewrote subsec. (f) and added subsecs. (f-1) to (f-5). Prior to amendment, subsec. (f) provided: "(f) Confidentiality of ancillary information.—

All working papers, recorded information, documents, and copies produced by, obtained by, or disclosed to the Mayor or any other person in the course of an examination made under this chapter must be given confidential treatment, are not subject to subpoena, and may not be

made public by the Mayor or any other person, except to the extent provided in subsection (e) of this section. Access may also be granted to the National Association of Insurance Commissioners. Parties must agree in writing prior to receiving the information to provide it the same confidential treatment required by this section, unless the prior written consent of the company to which it pertains has been obtained."

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7 of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 8 of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 7 of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 10-49. — For legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-1401.

Legislative history of Law 11-90. — Law 11-90, the "Insurance Omnibus Amendment

Act of 1995," was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1401.

Legislative history of Law 13-191. — Law 13-191, the "Insurer Confidentiality and Information Sharing Amendment Act of 2000," was introduced in Council and assigned Bill No. 13-706, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-419 and transmitted to both Houses of Congress for its review. D.C. Law 13-191 became effective on October 21, 2000.

§ 31-1405. Conflict of interest.

(a) No examiner may be appointed by the Mayor if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section shall not be construed to automatically preclude an examiner from being:

- (1) A policyholder or claimant under an insurance policy;
- (2) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;
- (3) An investment owner in shares of regulated diversified investment companies; or
- (4) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(b) Notwithstanding the requirements of this section, the Mayor may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

(Oct. 21, 1993, D.C. Law 10-49, § 6, 40 DCR 6110.)

Prior Codifications. — 1981 Ed., § 35-3605.

Legislative history of Law 10-49. — For

legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-1401.

§ 31-1406. Cost of examinations.

All expenses of the examinations shall be paid by the company examined, and the company shall timely pay the Mayor the actual expense of such an examination upon receipt of itemized bills provided by the Mayor. For purposes of expenses assessed and paid under this section, the provisions of Unit A of Chapter 3 of Title 2 shall not apply.

(Oct. 21, 1993, D.C. Law 10-49, § 7, 40 DCR 6110; Mar. 25, 2003, D.C. Law 14-236, § 4, 49 DCR 10483.)

Prior Codifications. — 1981 Ed., § 35-3606.

Effect of amendments. — D.C. Law 14-236 added the last sentence.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4 of Department of Insurance and Securities Regulation Procurement Temporary Act of 2002 (D.C. Law 14-159, June 25, 2002, law notification 49 DCR 6495).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4 of Department of Insurance and Securities Regulation Procurement Emergency Act of 2002 (D.C. Act 14-314, March 26, 2002, 49 DCR 3451).

For temporary (90 day) amendment of section, see § 4 of Department of Insurance and Securities Regulation Procurement Congressio-

nal Review Emergency Act of 2003 (D.C. Act 15-9, January 27, 2003, 50 DCR 1478).

Legislative history of Law 10-49. — For legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-1401.

Legislative history of Law 14-236. — Law 14-236, the “Department of Insurance and Securities Regulation Procurement Amendment Act of 2002”, was introduced in Council and assigned Bill No. 14-571, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on July 2, 2002, and October 1, 2002, respectively. Signed by the Mayor on October 23, 2002, it was assigned Act No. 14-515 and transmitted to both Houses of Congress for its review. D.C. Law 14-236 became effective on March 25, 2003.

§ 31-1407. Immunity from liability.

(a) No cause of action shall arise nor shall any liability be imposed against the Mayor, the Mayor’s authorized representatives, or an examiner appointed by the Mayor for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

(b) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Mayor or the Mayor’s authorized representative or examiner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (a) of this section.

(d) A person identified in subsection (a) of this section shall be entitled to an award of attorney’s fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section, the term “substantially justified” means a proceeding that had a reasonable basis in law or fact at the time that it was initiated.

(Oct. 21, 1993, D.C. Law 10-49, § 8, 40 DCR 6110.)

Prior Codifications. — 1981 Ed., § 35-3607. legislative history of D.C. Law 10-49, see Historical and Statutory Notes following § 31-

Legislative history of Law 10-49. — For 1401.

CHAPTER 15. MANAGING GENERAL AGENTS.

Sec.

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§ 31-1501. Definitions.

For the purposes of this chapter, the term:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "District" means the District of Columbia.

(3) "Insurer" means any person, firm, association, or corporation duly licensed in the District as an insurance company pursuant to §§ 31-4304 and 31-2502.02.

(4)(A) "Managing general agent" means any person, firm, association, or corporation who:

(i) Negotiates and binds ceding reinsurance contracts on behalf of an insurer; or

(ii) Manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office; and

(iii) Acts as an agent for such an insurer whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premiums equal to or more than 5% of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year, and, in addition, adjusts or pays claims in excess of an amount determined by the Mayor, or negotiates reinsurance on behalf of the insurer.

(B) Notwithstanding the above definition, the term "managing general agent" shall not apply to the following persons for the purposes of this chapter:

(i) An employee of the insurer;

(ii) A United States manager of the United States branch of an alien insurer;

(iii) An underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to Chapter 7 of this title, or its predecessor, and whose compensation is not based on the volume of premiums written; or

(iv) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(5) "Producers" means an insurance broker or brokers or any other person, firm, association, or corporation, when for any compensation, commission or other thing of value, such person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation.

(6) "Underwrite" means the authority to accept or reject risks on behalf of the insurer.

(Oct. 21, 1993, D.C. Law 10-41, § 2, 40 DCR 6014; Apr. 18, 1996, D.C. Law 11-110, § 41, 43 DCR 530.)

Section references. — This section is referred to in § 31-1504.

Prior Codifications. — 1981 Ed., § 35-3001.

Legislative history of Law 10-41. — Law 10-41, the "Managing General Agents Act of 1993," was introduced in Council and assigned Bill No. 10-125, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 5, 1993, it was assigned Act No. 10-76 and transmitted to both Houses of Congress for its review. D.C. Law 10-41 became effective on October 21, 1993.

Legislative history of Law 11-110. — Law 11-110, the "Technical Amendments Act of 1996," was introduced in Council and assigned

Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-41, the Managing General Agents Act of 1993, see Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

Editor's notes. — Mayor authorized to issue rules: Section 8 of D.C. Law 10-41 provided that the Mayor shall, pursuant to subchapter I of Chapter 15 of Title 1 subchapter I of Chapter 5 of Title 2, 2001 Ed., issue rules to implement the provisions of this chapter.

§ 31-1502. Licensure.

(a) No person, firm, association, or corporation shall act in the capacity of a managing general agent with respect to risks located in the District for an insurer licensed in the District, unless the person is a licensed broker in the District.

(b) No person, firm, association, or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in the District with respect to risks located outside the District, nor shall an insurer utilize the services of such a managing general agent, unless the person is licensed as a broker in the District, which license may be a nonresident license, pursuant to the provisions of this chapter.

(c) The Mayor may require a bond in an amount acceptable to him or her for the protection of the insurer.

(d) The Mayor may require the managing general agent to maintain an errors and omissions policy.

(Oct. 21, 1993, D.C. Law 10-41, § 3, 40 DCR 6014; May 16, 1995, D.C. Law 10-255, § 29(a), 41 DCR 5193.)

Prior Codifications. — 1981 Ed., § 35-3002.

Legislative history of Law 10-41. — For legislative history of D.C. Law 10-41, see Historical and Statutory Notes following § 31-1501.

Legislative history of Law 10-255. — Law 10-255, the "Technical Amendments Act of 1994," was introduced in Council and assigned

Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

§ 31-1503. Required contract provisions.

No person, firm, association, or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and where both parties share responsibility for a particular function, specifies the division of the responsibilities, and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held in a separate account by the managing general agent in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than 3 months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the managing general agent will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the Mayor shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the Mayor. These records shall be retained according to Chapter 14 of this title, and §§ 31-4440 and 31-5204.

(5) The contract may not be assigned in whole or part by the managing general agent.

(6) Appropriate underwriting guidelines are required, including:

- (A) The maximum annual premium volume;
- (B) The basis of the rates to be charged;
- (C) The types of risks which may be written;
- (D) Maximum limits of liability;
- (E) Applicable exclusions;
- (F) Territorial limitations;
- (G) Policy cancellation provisions; and
- (H) The maximum policy period.

(7) The insurer shall have the right to cancel or not renew any policy of insurance subject to the applicable laws and regulations of the District governing the cancellation and nonrenewal of insurance policies.

(8) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(A) All claims must be reported to the company within 48 hours of receipt.

(B) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

- (i) Has the potential to exceed an amount determined by the Mayor or exceeds the limit set by the company, whichever is less;
- (ii) Involves a coverage dispute;
- (iii) May exceed the managing general agent's claims settlement authority;
- (iv) Is open for more than 6 months; or
- (v) Is closed by payment of an amount set by the Mayor or an amount set by the company, whichever is less.

(C) All claim files will be the joint property of the insurer and managing general agent. Upon an order of liquidation of the insurer, however, these files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis.

(D) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(9) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(10) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until 1 year after they are earned for property insurance business and 5 years after they are earned on casualty business and not until the profits have been verified pursuant to § 31-1504.

(11) The managing general agent shall not:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(B) Commit the insurer to participate in insurance or reinsurance syndicates;

(C) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed;

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1% of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(E) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(F) Permit its subproducer to serve on the insurer's board of directors;

- (G) Jointly employ an individual who is employed with the insurer; or
- (H) Appoint a submanaging general agent.

(Oct. 21, 1993, D.C. Law 10-41, § 4, 40 DCR 6014; May 16, 1995, D.C. Law 10-255, § 29(b), 41 DCR 5193.)

Prior Codifications. — 1981 Ed., § 35-3003.

Legislative history of Law 10-41. — For legislative history of D.C. Law 10-41, see Historical and Statutory Notes following § 31-1501.

Legislative history of Law 10-255. — For legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1502.

§ 31-1504. Duties of insurers.

(a) The insurer shall have on file an independent financial examination, in a form acceptable to the Mayor, of each managing general agent with which it has done business.

(b) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(c) The insurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(e) Within 30 days of entering into or terminating a contract with a managing general agent, the insurer shall provide written notification of the appointment or termination to the Mayor. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the Mayor may request.

(f) An insurer shall review its books and records each quarter to determine if any producer has, because of § 31-1501(4), become a managing general agent as defined in that section. If the insurer determines that a producer has become a managing general agent pursuant to the above, the insurer shall promptly notify the producer and the Mayor of the determination, and the insurer and producer shall fully comply with the provisions of this chapter within 30 days.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer, or controlling shareholder of its managing general agents. This subsection shall not apply to relationships governed by Chapter 7 of this title or, if applicable, Chapter 4 of this title.

(Oct. 21, 1993, D.C. Law 10-41, § 5, 40 DCR 6014; May 16, 1995, D.C. Law 10-255, § 29(c), 41 DCR 5193.)

Section references. — This section is referred to in § 31-1503.

Prior Codifications. — 1981 Ed., § 35-3004.

Legislative history of Law 10-41. — For legislative history of D.C. Law 10-41, see His-

torical and Statutory Notes following § 31-1501.

Legislative history of Law 10-255. — For legislative history of D.C. Law 10-255, see Historical and Statutory Notes following § 31-1502.

§ 31-1505. Examination authority.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

(Oct. 21, 1993, D.C. Law 10-41, § 6, 40 DCR 6014.)

Prior Codifications. — 1981 Ed., § 35-3005.

Legislative history of Law 10-41. — For

legislative history of D.C. Law 10-41, see Historical and Statutory Notes following § 31-1501.

§ 31-1506. Penalties and liabilities.

(a) If the Mayor determines that the managing general agent or any other person has not materially complied with this chapter, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the Mayor may order:

(1) For each separate violation, a penalty in an amount not exceeding \$10,000, or not more than \$25,000 for intentional violations;

(2) Revocation or suspension of the producer's license; and

(3) If it was found that because of material noncompliance the insurer has suffered any loss or damage, the Commissioner may maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors, or other appropriate relief.

(b) The decision, determination, or order of the Mayor pursuant to subsection (a) of this section shall be subject to judicial review pursuant to subchapter I of Chapter 5 of Title 2, §§ 31-2502.43 [repealed] and 31-2502.44 [repealed], and §§ 31-4327 [repealed] and 31-4332.

(c) Nothing in this section shall affect the right of the Mayor to impose any other penalties provided in the insurance law of the District.

(d) Nothing in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

(Oct. 21, 1993, D.C. Law 10-41, § 7, 40 DCR 6014; Apr. 26, 1994, D.C. Law 10-103, § 5, 41 DCR 1005.)

Cross references. — Hospital and medical services corporations, applicable law, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-3006.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 5(a) of Insurance Omnibus Temporary

Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-41. — For legislative history of D.C. Law 10-41, see Historical and Statutory Notes following § 31-1501.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment

Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and Feb-

ruary 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

CHAPTER 16. PROHIBITION OF DISCRIMINATION IN THE PROVISION OF INSURANCE ON BASIS OF AIDS TEST.

Sec.

- 31-1601. Definitions.
- 31-1602. Application of chapter.
- 31-1603. Prohibited actions.
- 31-1604. AIDS testing standards, protocols, and appeals.
- 31-1605. Diagnosis of AIDS.
- 31-1606. Informed consent requirements; restrictions on disclosure.

Sec.

- 31-1607. Contestability.
- 31-1608. Special enforcement provisions.
- 31-1609. Rules.
- 31-1610. Prohibition against discrimination in use of AIDS tests.

§ 31-1601. Definitions.

For the purposes of this chapter, the term:

(1) "AIDS" means acquired immune deficiency syndrome as defined by the Centers for Disease Control of the United States Public Health Service.

(2) "ARC" means AIDS-related complex as defined by the Centers for Disease Control of the United States Public Health Service or, during any period when the Centers for Disease Control have not issued a definition, by the District of Columbia Commission of Public Health.

(3) "District" means the District of Columbia.

(3A) "Gender identity or expression" shall have the same meaning as provided in § 2-1401.02(12A).

(4) "Health maintenance organization" or "HMO" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollees responsibility for co-payments and deductibles, and qualifies as a health maintenance organization under Chapter 34 of Title 31.

(5) "HIV" means human immunodeficiency virus.

(6) "Mayor" means the Mayor of the District of Columbia.

(7) "Insurer" means any individual, partnership, corporation, association, fraternal benefit association, nonprofit health service plan, health maintenance organization, or other business entity that issues, amends, or renews individual or group health, disability, or life insurance policies or contracts, including health maintenance organization membership contracts, in the District. The term "insurer" shall include Group Hospitalization and Medical Services, Incorporated.

(Aug. 7, 1986, D.C. Law 6-132, § 2, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(a), 36 DCR 471; June 18, 2003, D.C. Law 14-312, § 301, 50 DCR 306; June 25, 2008, D.C. Law 17-177, § 15(a), 55 DCR 3696.)

Prior Codifications. — 1981 Ed., § 35-221.

Effect of amendments. — D.C. Law 14-312 rewrote par. (4) which had read as follows: "(4) 'Health maintenance organization' means a public or private organization that is a qualifying health maintenance organization under federal regulations, or has been determined to be a health maintenance organization pursuant

to regulations adopted by the State Health Planning and Development Agency of the District of Columbia."

D.C. Law 17-177 added par. (3A).

Legislative history of Law 6-132. — Law 6-132, the "Prohibition of Discrimination in the Provision of Insurance Act of 1986," was introduced in Council and assigned Bill No. 6-343,

which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on May 13, 1986, and May 27, 1986, respectively. Signed by the Mayor on June 6, 1986, it was assigned Act No. 6-170 and transmitted to both Houses of Congress for its review.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

Legislative history of Law 14-312. — Law 14-312, the “Health Organizations RBC Amendment Act of 2002”, was introduced in Council and assigned Bill No. 14-159, which was referred to the Committee on Human Services. The Bill was adopted on first and second readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on

December 23, 2002, it was assigned Act No. 14-571 and transmitted to both Houses of Congress for its review. D.C. Law 14-312 became effective on June 18, 2003.

Legislative history of Law 17-177. — Law 17-177, the “Prohibition of Discrimination on the Basis of Gender Identity and Expression Amendment Act of 2008”, was introduced in Council and assigned Bill No. 17-330, which was referred to the Committee on Workforce Development and Government Operations. The Bill was adopted on first and second readings on February 5, 2008, and March 4, 2008, respectively. Signed by the Mayor on March 19, 2008, it was assigned Act No. 17-329 and transmitted to both Houses of Congress for its review. D.C. Law 17-177 became effective on June 25, 2008.

§ 31-1602. Application of chapter.

The requirements of this chapter shall apply to the practices and procedures employed by insurers and their agents and employees in making determinations about any individual or group policy or contract of health, disability, or life insurance.

(Aug. 7, 1986, D.C. Law 6-132, § 3, 33 DCR 3615.)

Prior Codifications. — 1981 Ed., § 35-222.
Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see His-

torical and Statutory Notes following § 31-1601.

§ 31-1603. Prohibited actions.

(a) Repealed.

(b)(1) In determining whether to issue, cancel, or renew insurance coverage, an insurer may not use age, marital status, geographic area of residence, occupation, sex, sexual orientation, gender identity or expression, or any similar factor or combination of factors for the purpose of seeking to predict whether any individual may in the future develop AIDS or ARC.

(2) In determining rates, premiums, dues, assessments, benefits covered, or expenses reimbursable, or in any other aspect of insurance marketing or coverage, an insurer may not use age, marital status, geographic area of residence, occupation, sex, sexual orientation, gender identity or expression, or any similar factor or combination of factors for the purpose of seeking to predict whether any individual may in the future develop AIDS or ARC.

(c) No health or disability insurance policy or contract shall contain any exclusion, reduction, other limitation of coverage, deductibles, or coinsurance provisions related to the care and treatment of AIDS, ARC, HIV infection, or any illness or disease arising from these medical conditions, unless the provisions apply generally to all benefits under the policy or contract.

(d) No life insurance policy or contract shall contain any exclusion, reduction, or other limitation of benefits related to AIDS, ARC, HIV infection, or any disease arising from these medical conditions, as a cause of death.

(Aug. 7, 1986, D.C. Law 6-132, § 4, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(b), 36 DCR 471; June 25, 2008, D.C. Law 17-177, § 15(b), 55 DCR 3696.)

Prior Codifications. — 1981 Ed., § 35-223.

Effect of amendments. — D.C. Law 17-177, in subsec. (b), substituted “sexual orientation, gender identity or expression” for “sexual orientation”.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

Legislative history of Law 17-177. — For Law 17-177, see notes following § 31-1601.

CASE NOTES

ANALYSIS

Misrepresentations.
Screening tests.

Misrepresentations.

Under District of Columbia law, insured's failure to disclose her prior alcoholism treatment on application for life policy was a material misrepresentation permitting insurer to invalidate policy, where insurer would have denied application if medical history had been disclosed. D.C. Code 1981, § 35-414. *Hood v. Prudential Ins. Co.*, 758 F. Supp. 764, 1991 U.S. Dist. LEXIS 2992 (1991).

Under District of Columbia law, insurance agent's preparation of life insurance application that contained misrepresentations concerning insured's medical history did not estop insurer from invalidating policy on grounds of misrepresentations, absent showing that insured was unaware that application contained false answers when she signed it. *Hood v. Prudential Ins. Co.*, 758 F. Supp. 764, 1991 U.S. Dist. LEXIS 2992 (1991).

Even assuming that insurance agent's alleged misrepresentation of his authority to write policy for District of Columbia residents and misstatement of address on application could be imputed to insurer, beneficiary under life policy did not have colorable claim for injury against insurer after insurer denied coverage under policy; policy would not have been

issued if alleged misrepresentation had not been made, and there was no reason to believe that insured could have received coverage from another insurer, given her medical history. *Hood v. Prudential Ins. Co.*, 758 F. Supp. 764, 1991 U.S. Dist. LEXIS 2992 (1991).

Screening tests.

Authoritative report indicating high reliability of AIDS screening tests was not admissible to prove irrationality of city ordinance prohibiting any insurers from using results of those tests for purpose of adjusting rates, where that report was not before city council at time ordinance was adopted. *American Council of Life Ins. v. District of Columbia*, 645 F. Supp. 84, 1986 U.S. Dist. LEXIS 20112 (1986).

Due process was not violated by ordinance imposing five-year moratorium on use of AIDS screening tests for purposes of adjusting insurance rates, premiums, dues, or assessments; ordinance was rationally related to legitimate purpose of securing access to care and treatment for individuals susceptible to AIDS virus, in view of medical testimony as to potential positive effects ordinance would have on public health program and evidence before counsel at time ordinance was adopted which indicated screening tests were unreliable. U.S.C. Const. Amend. 5. *American Council of Life Ins. v. District of Columbia*, 645 F. Supp. 84, 1986 U.S. Dist. LEXIS 20112 (1986).

§ 31-1604. AIDS testing standards, protocols, and appeals.

(a)(1) Within 30 days of March 16, 1989, the District of Columbia Commissioner of Public Health (“Commissioner”) shall certify the testing protocol that is the most reliable and accurate in identifying exposure to the probable causative agent of AIDS, ARC, and the HIV infection. The notice of certification shall include an estimate based on scientific evidence of the proportion of false positive results expected in use of the testing protocol.

(2) Within 12 months from the date of the initial certification and at least

annually thereafter, the Commissioner shall publish a new or renewal certification based upon an ongoing review of scientific evidence regarding the accuracy and reliability of the testing protocol.

(b)(1) A named insured who tests positive under the testing protocol certified by the Commissioner may appeal to the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] to review the testing procedures and results, and may present additional medical evidence, including the results of similar tests for exposure to the probable causative agent of AIDS that the named insured independently obtains, to rebut the positive test results. If the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] determines that the result of the test of the proposed insured is not a true positive, the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] shall order the insurer from which the applicant sought coverage to disregard the positive test result. The Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] shall, when necessary, request the advice of the Commissioner in making this determination.

(2) Hearings related to the appeal provided for in paragraph (1) of this subsection shall be held in accordance with subchapter I of Chapter 5 of Title 2.

(3) An insurer shall apply standard underwriting practices, in accordance with applicable laws and rules of the District, to all life, health, or disability income insurance policies or contracts for individuals who test positive under the testing protocol certified by the Commissioner.

(Aug. 7, 1986, D.C. Law 6-132, § 5, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(c), 36 DCR 471; May 21, 1997, D.C. Law 11-268, § 10(g), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1606.

Prior Codifications. — 1981 Ed., § 35-224.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see His-

torical and Statutory Notes following § 31-1610.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-1605. Diagnosis of AIDS.

(a) Nothing in this chapter shall be construed as preventing or restricting insurers or their agents or employees from following standard procedures for determining the insurability of or establishing the rates or premiums for new applicants diagnosed by a licensed physician as having AIDS, provided that the procedures:

- (1) Apply in the same manner to all other new applicants within the same category of insurance;
- (2) Are justified on the basis of actuarial evidence; and
- (3) Comply with other laws and rules of the District.

(b) Repealed.

(Aug. 7, 1986, D.C. Law 6-132, § 6, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(d), 36 DCR 471.)

Prior Codifications. — 1981 Ed., § 35-225.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

§ 31-1606. Informed consent requirements; restrictions on disclosure.

(a) No insurer shall request or require a proposed insured to take the testing protocol certified pursuant to § 31-1604 without first obtaining the signature of the proposed insured or the legal guardian of the named insured on a standard informed consent statement prepared and furnished by the Commissioner of Insurance and Securities.

(b) An insurer shall provide information about the availability of counseling at public and private health facilities to each proposed insured who the insurer requests or requires to take the testing protocol.

(c) Before any proposed insured or his or her legal guardian is requested to sign an informed consent statement, the insurer shall provide the proposed insured, or his or her legal guardian an explanation of the nature of AIDS, ARC, and the HIV infection, an explanation of the testing protocol, including its purpose, potential uses, limitations, and an updated percentage of false positives, and notice of the right of the proposed insured to appeal to the Commissioner of Insurance and Securities, an explanation of the meaning of test results, and a description of the disclosure restrictions established by this chapter.

(d) Once an insurer has requested a signature on an informed consent statement pursuant to subsection (a) of this section, and has complied with subsections (b) and (c) of this section, the proposed insured or legal guardian of the proposed insured may wait 14 days before signing the informed consent statement.

(1) An insurer shall not disclose the fact that a proposed insured was tested or the results of the test except to:

- (A) The proposed insured or the legal guardian of the proposed insured;
- (B) A court of competent jurisdiction, pursuant to a lawful court order;

or

(C) Any person named in a written authorization executed by the proposed insured or the legal guardian of the proposed insured.

(2) An insurer that requires testing of a proposed insured shall maintain records and establish procedures in a manner that protects the privacy of the proposed insured and the confidentiality of the test results.

(3)(A) The Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] may, by rule, require an insurer to report numerical data regarding test results to the Commissioner

for the limited purpose of performing epidemiological studies. The name, address, or other information that reveals the identity of the individual tested shall not be reported to the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking].

(B) An insurer shall report numerical data regarding test results to actuaries employed or consulted by the insurer for the limited purpose of performing actuarial studies related to the business of insurance. The name, address, or other information that reveals the identity of the individual tested shall not be reported to the actuaries.

(Aug. 7, 1986, D.C. Law 6-132, § 7, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(e), 36 DCR 471; Feb. 5, 1994, D.C. Law 10-68, § 30, 40 DCR 6311; May 21, 1997, D.C. Law 11-268, § 10(g), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1608.

Prior Codifications. — 1981 Ed., § 35-226.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

Legislative history of Law 10-68. — Law 10-68, the "Technical Amendments Act of 1993,"

was introduced in Council and assigned Bill No. 10-166, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 23, 1993, it was assigned Act No. 10-107 and transmitted to both Houses of Congress for its review. D.C. Law 10-68 became effective on February 5, 1994.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

§ 31-1607. Contestability.

An insurer may contest the validity of a policy or contract for 3 years from the date of issuance, amendment, or renewal of the policy or contract, if the basis for contesting the validity is that the insured knowingly failed or refused to disclose to the insurer that he or she had AIDS at the time of issuance, amendment, or renewal of any policy issued under this chapter, and the insurance company was prohibited by law from conducting a test to determine the exposure of the insured to the AIDS virus on the date the insurer and insured entered into a contract.

(Aug. 7, 1986, D.C. Law 6-132, § 8, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(f), 36 DCR 471.)

Prior Codifications. — 1981 Ed., § 35-227.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

§ 31-1608. Special enforcement provisions.

(a) An insurer, or an agent, broker or employee of the insurer who violates any provision of this chapter or rule issued pursuant to this chapter shall be subject to the suspension or revocation of its license or certificate of authority to transact business in the District, as appropriate, in accordance with the

provisions of §§ 31-2502.03, 31-2502.36 [repealed], 31-4305, and 31-4326 [repealed], or other applicable District laws.

(b) Any person who violates the restrictions on disclosure in § 31-1606(d) shall be fined not less than \$500 or more than \$5,000 for each disclosure. In the case of an insurer or an agent, broker or employee of an insurer, the fine shall be in addition to the penalties provided in subsection (a) of this section.

(c) Any person injured as the result of a violation of this chapter, or a rule issued pursuant to this chapter, may bring an action for civil damages and other appropriate relief in the Superior Court of the District of Columbia without first pursuing administrative remedies.

(Aug. 7, 1986, D.C. Law 6-132, § 9, 33 DCR 3615; Mar. 16, 1989, D.C. Law 7-208, § 2(g), 36 DCR 471.)

Prior Codifications. — 1981 Ed., § 35-228.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see Historical and Statutory Notes following § 31-1601.

Legislative history of Law 7-208. — For legislative history of D.C. Law 7-208, see Historical and Statutory Notes following § 31-1610.

§ 31-1609. Rules.

The Mayor shall issue proposed rules, within 90 days of August 7, 1986, to implement the provisions of this chapter. The proposed rules shall be submitted to the Council of the District of Columbia ("Council") for a 45-day period of review, excluding Saturdays, Sundays, holidays, and days of Council recess. If the Council does not disapprove the proposed rules by resolution, within the 45-day review period, the proposed rules shall be deemed approved. The Council may approve or disapprove the proposed rules, in whole or in part, by resolution prior to the expiration of the 45-day review period.

(Aug. 7, 1986, D.C. Law 6-132, § 10, 33 DCR 3615.)

Prior Codifications. — 1981 Ed., § 35-229.

Legislative history of Law 6-132. — For legislative history of D.C. Law 6-132, see His-

torical and Statutory Notes following § 31-1601.

§ 31-1610. Prohibition against discrimination in use of AIDS tests.

(a) No insurer shall inquire about the sexual orientation or gender identity or expression of an applicant in an application for health, life, or disability income insurance coverage or in an investigation conducted by an insurer or insurance support organization on behalf of an insurer in connection with an application for the coverage.

(b) Sexual orientation or gender identity or expression, shall not be used as a factor in the underwriting process or in the determination of insurability.

(c) Insurance support organizations shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation or gender identity or expression of a proposed insured.

(d) An insurance company shall not use sexual orientation, gender identity

or expression, lifestyle, living arrangements, occupation, gender, or beneficiary designation to determine whether to test an individual who applies for life, health, or disability income insurance.

(Aug. 7, 1986, D.C. Law 6-132, § 11, as added Mar. 16, 1989, D.C. Law 7-208, § 2(h), 36 DCR 471; June 25, 2008, D.C. Law 17-177, § 15(c), 55 DCR 3696.)

Prior Codifications. — 1981 Ed., § 35-230.

Effect of amendments. — D.C. Law 17-177, in subsecs. (a) and (c), substituted “sexual orientation or gender identity or expression” for “sexual orientation”; in subsec. (b), substituted “Sexual orientation or gender identity or expression, shall not” for “Sexual orientation shall not”; and, in subsec. (d), substituted “sexual orientation, gender identity or expression” for “sexual orientation”.

Legislative history of Law 7-208. — Law 7-208, the “Prohibition of Discrimination in the

Provision of Insurance Amendment Act of 1988,” was introduced in Council and assigned Bill No. 7-364, which was referred to the Committee on Finance and Revenue. The Bill was adopted on first and second readings on November 29, 1988, and December 13, 1988, respectively. Signed by the Mayor on January 6, 1989, it was assigned Act No. 7-279 and transmitted to both Houses of Congress for its review.

Legislative history of Law 17-177. — For Law 17-177, see notes following § 31-1601.

CHAPTER 16A. PUBLIC INSURANCE ADJUSTER LICENSURE.

Sec.	Sec.
31-1631.01. Short title.	31-1631.08. Contracts and solicitation of contracts.
31-1631.02. Definitions.	31-1631.09. Adjustments to comply with insurance contract and law.
31-1631.03. License requirement.	31-1631.10. Regulations.
31-1631.04. Licensure.	31-1631.11. [Reserved].
31-1631.05. Bond requirement.	31-1631.12. Scope.
31-1631.06. Maintenance of records.	
31-1631.07. License denial, suspension, revocation, and refusal to renew; civil penalties.	

§ 31-1631.01. Short title.

This chapter may be cited as the “Public Insurance Adjuster Licensure Act of 2002.”

(Mar. 27, 2003, D.C. Law 14-256, § 1, 50 DCR 238.)

Legislative history of Law 14-256. — Law 14-256, the “Public Insurance Adjuster Licensure Act of 2002”, was introduced in Council and assigned Bill No. 14-476, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 23, 2002, it was assigned Act No. 14-553 and transmitted to both Houses of Congress for its review. D.C. Law 14-256 became effective on March 27, 2003.

§ 31-1631.02. Definitions.

For the purposes of this chapter, the term:

(1) “Commissioner” means the Commissioner of Insurance and Securities Regulation [Commissioner of the Department of Insurance, Securities, and Banking].

(2) “District” means the District of Columbia.

(3) “License” means a license issued by the Commissioner to act as a public insurance adjuster.

(4) “Licensee” means any person licensed in the District to do business as a public insurance adjuster.

(5) “Public insurance adjuster” shall include any person who, for compensation or any other thing of value:

(A) Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured individual in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(B) Advertises for employment as an adjuster of insurance claims; solicits business or represents himself or herself to the public as an adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(C) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

(Mar. 27, 2003, D.C. Law 14-256, § 2, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.03. License requirement.

No person shall, directly or indirectly, act as a public insurance adjuster without first procuring a license from the Commissioner to act as a public insurance adjuster.

(Mar. 27, 2003, D.C. Law 14-256, § 3, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.04. Licensure.

(a) The Commissioner shall issue a license to an applicant for a public insurance adjuster's license who:

- (1) Has paid the applicable fee established by the Commissioner by rule;
- (2) Passes a written examination for which a fee may be charged; and
- (3) Has sufficient experience, training, and instruction concerning the adjusting of first party claims for damages or losses under insurance contracts that insure the real or personal property of the insured, as determined by the Commissioner in accordance with regulations issued pursuant to this chapter.

(b) The Commissioner may issue a license to any applicant without an examination if:

- (1) The applicant holds a like license in good standing from another state and the public official having supervision of public insurance adjusters in the other state certifies that the applicant has passed a written examination; and
- (2) The other state recognizes public insurance adjusters with District public insurance adjuster licenses for the purpose of licensing the applicant without the requirement of an examination.

(c) A license issued pursuant to this section shall continue in force from the date of issuance until April 30th of the next odd-numbered year, unless suspended, revoked, or otherwise terminated prior thereto. Requests for renewal of the license shall be made to the Commissioner and accompanied by the license fee. Unless a request for renewal, accompanied by the appropriate fee, is received by the termination date, the license shall expire.

(Mar. 27, 2003, D.C. Law 14-256, § 4, 50 DCR 238; Sept. 24, 2010, D.C. Law 18-223, § 2172, 57 DCR 6242.)

Effect of amendments. — D.C. Law 18-223, in subsec. (a)(1), substituted “established by the Commissioner by rule” for “specified by this chapter”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2172 of Fiscal Year 2011 Budget Support Emergency

Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

Short title. — Short title: Section 2171 of

D.C. Law 18-223 provided that subtitle N of Insurance Adjuster Licensure Amendment Act title II of the act may be cited as the "Public of 2010".

§ 31-1631.05. Bond requirement.

(a) At the time of the application for license as a public insurance adjuster, the applicant shall file with the Commissioner a bond executed and issued by a surety insurer authorized to transact business in the District in the amount of \$20,000, which bond shall serve the faithful performance of his or her duties as a public insurance adjuster. A public insurance adjuster license shall automatically terminate when the bond is not in force.

(b) The bond shall have the following characteristics:

(1) The bond shall be in favor of the District and shall specifically authorize recovery by the Commissioner of the damages sustained if the licensee is convicted of fraud or unfair practices in connection with his or her business as a public insurance adjuster.

(2) The aggregate liability of the surety for all damages shall not exceed the amount of the bond.

(3) The bond shall not be terminated unless at least 30 days written notice is given to the licensee and filed with the Commissioner.

(Mar. 27, 2003, D.C. Law 14-256, § 5, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.06. Maintenance of records.

(a) A public insurance adjuster shall maintain a complete record of each transaction as a public insurance adjuster. The records required by this section shall include the:

(1) Name of the insured;

(2) Date, location, and amount of the loss;

(3) Copy of the contract between the public insurance adjuster and insured;

(4) Name of the insurer, amount, expiration date, and number of each policy carried with respect to the loss;

(5) Itemized statement of the insured's recoveries; and

(6) Itemized statement of all compensation received by the public insurance adjuster, from any source whatsoever, in connection with a particular claim.

(b) Records shall be maintained for at least 5 years after the termination of the transaction with an insured and shall be open to examination by the Commissioner at all times.

(c) Records submitted in accordance with this section that contain proprietary information, identified in writing as such by the public insurance adjuster, shall be treated as confidential by the Commissioner.

(Mar. 27, 2003, D.C. Law 14-256, § 6, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.07. License denial, suspension, revocation, and refusal to renew; civil penalties.

(a) The Commissioner may deny a license to an applicant or suspend, revoke, or refuse to renew a license if the applicant or licensee:

- (1) Violates the provisions of this chapter or any standard of conduct prescribed by the Commissioner in regulations;
- (2) Makes a material misstatement in the application for the license;
- (3) Engages in fraudulent or dishonest practices; or
- (4) Demonstrates incompetency or untrustworthiness to act as a public insurance adjuster.

(b) Upon a finding by the Commissioner of a violation of subsection (a)(1) or (3) of this section, the Commissioner may impose a civil penalty not to exceed \$1,000 for each violation.

(c) This chapter shall not be applied or interpreted to bar a borrower from bringing an action pursuant to any District or federal law for damages, injunctive relief, or any other relief.

(Mar. 27, 2003, D.C. Law 14-256, § 7, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.08. Contracts and solicitation of contracts.

(a) No licensee shall, directly or indirectly, act within the District as a public insurance adjuster without having first entered into a contract, in writing, on a form approved by the Commissioner and executed in duplicate by the public insurance adjuster and the insured or a duly authorized representative. One copy of the contract shall be kept on file by the licensee and available at all times for inspection without notice by the Commissioner.

(b)(1) An insured who contracts for the services of a public insurance adjuster shall have the right to cancel the contract until midnight on the 3rd business day after the day on which he or she signs the contract. Contracts that do not substantially conform to the requirements contained in this section shall be void. Cancellation of the contract shall be effective when mailed if the following conditions are met:

(A) The cancellation shall be in writing, but need not take a particular form, and shall be sufficient if it indicates the intent of the person not to go forward with the representation.

(B) The right to cancel shall be contained in the approved contract prescribed by this chapter.

(2) The right of recession contained in this subsection shall be in addition to, and not in limitation of, any other rights of the insured.

(3) In a commercial loss, if a contract is cancelled in accordance with this subsection, the public insurance adjuster shall be entitled to reasonable

compensation for actual services rendered and costs incurred between the time the contract was entered into and the time it was cancelled.

(c) A licensee shall not solicit, or attempt to solicit, a client for employment during the progress of a loss-producing occurrence, as defined in the client's insurance contract.

(d) A licensee shall not permit an unlicensed employee or agent in his or her own name to advertise, engage clients, furnish reports, or present bills to clients, or in any manner whatsoever to conduct business for which a license is required under this chapter.

(e) A licensee shall not charge the client a fee that exceeds 10% of the total insurance recovery of the client.

(Mar. 27, 2003, D.C. Law 14-256, § 8, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.09. Adjustments to comply with insurance contract and law.

A public insurance adjuster shall adjust or investigate every claim, damage, or loss made or occurring under an insurance contract for which the public insurance adjuster has been employed in accordance with the terms and conditions of his or her contract with the insured and the applicable laws and regulations of the District.

(Mar. 27, 2003, D.C. Law 14-256, § 9, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.10. Regulations.

The Commissioner shall promulgate rules and regulations as are necessary to carry out this chapter.

(Mar. 27, 2003, D.C. Law 14-256, § 10, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

§ 31-1631.11. [Reserved].

§ 31-1631.12. Scope.

This chapter shall not apply to:

(1) An adjuster for or an agent or employee of an insurer or group of insurers under common control or ownership that, as a representative of the insurer or group, adjusts losses or damages under policies issued by the insurer or group;

- (2) A broker that acts as an adjuster without compensation for an insured for whom the broker is acting as a broker;
- (3) An attorney at law who does not:
 - (A) Regularly act as a public insurance adjuster; or
 - (B) Represent to the public by sign, advertisement, or other written or oral communication indicating that the attorney at law acts as a public insurance adjuster; or
- (4) A licensed health care provider, or employee of a licensed health care provider, who prepares or files a health insurance claim form on behalf of a patient, a licensed insurance agent, or salaried employee of an insurance company.

(Mar. 27, 2003, D.C. Law 14-256, § 12, 50 DCR 238.)

Legislative history of Law 14-256. — For Law 14-256, see notes following § 31-1631.01.

CHAPTER 17. REDOMESTICATION.

Sec.

31-1701. Definitions.

31-1702. Approval as a domestic insurer.

31-1703. Conversion to foreign insurer.

Sec.

31-1704. Effects of redomestication.

31-1705. Rulemaking.

§ 31-1701. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance, Securities and Banking.

(1A) "District" means the District of Columbia.

(2) "Redomestication" means the transfer to the District the corporate domicile of an authorized foreign insurance company.

(3) Repealed.

(4) "Transferring insurer" means any authorized foreign insurance company seeking redomestication.

(May 24, 1996, D.C. Law 11-127, § 2, 43 DCR 1559; Mar. 24, 1998, D.C. Law 12-81, § 44(a), 45 DCR 745; Apr. 13, 2005, D.C. Law 15-354, § 46(a), 52 DCR 2638.)

Prior Codifications. — 1981 Ed., § 35-4301.

Effect of amendments. — D.C. Law 15-354, in par. (1), substituted "of the Department of Insurance, Securities, and Banking" for "of Insurance and Securities Regulation".

Legislative history of Law 11-127. — Law 11-127, the "Insurance Redomestication Act of 1996," was introduced in Council and assigned Bill No. 11-390, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on February 6, 1996, and March 5, 1996, respectively. Signed by the Mayor on March 15, 1996, it was assigned Act No. 11-234 and transmitted to both Houses of Congress for

its review. D.C. Law 11-127 became effective on May 24, 1996.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

§ 31-1702. Approval as a domestic insurer.

Any insurer which is organized under laws of any state and is admitted to do business in the District for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in the District. The domestic insurer shall be entitled to like certificates and licenses to transact business in the District, and shall be subject to the authority and jurisdiction of the District.

(May 24, 1996, D.C. Law 11-127, § 3, 43 DCR 1559.)

Prior Codifications. — 1981 Ed., § 35-4302.

Legislative history of Law 11-127. — For legislative history of D.C. Law 11-127, see His-

torical and Statutory Notes following § 31-1701.

§ 31-1703. Conversion to foreign insurer.

Any domestic insurer may, upon the approval of the Commissioner, transfer its domicile to any state in which it is admitted to transact the business of insurance, and upon such a transfer shall cease to be a domestic insurer and shall be admitted to the District, if qualified, as a foreign insurer. The Commissioner shall approve any proposed transfer unless he or she determines such a transfer is not in the best interest of the policyholders of the District.

(May 24, 1996, D.C. Law 11-127, § 4, 43 DCR 1559; Mar. 24, 1998, D.C. Law 12-81, § 44(b), 45 DCR 745; Apr. 13, 2005, D.C. Law 15-354, § 46(b), 52 DCR 2638.)

Prior Codifications. — 1981 Ed., § 35-4303.

Effect of amendments. — D.C. Law 15-354 deleted “of Insurance and Securities” following “approval of the Commissioner”.

Legislative history of Law 11-127. — For legislative history of D.C. Law 11-127, see Historical and Statutory Notes following § 31-1701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-1701.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

§ 31-1704. Effects of redomestication.

(a) The certificate of authority, agent appointments and licenses, rates, and other items which the Commissioner allows, in his or her discretion, which are in existence at the time any insurer licensed to transact the business of insurance in the District transfers its corporate domicile to the District or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon the transfer if the insurer remains duly qualified to transact the business of insurance in the District. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Commissioner.

(b) Every transferring insurer shall file new policy forms with the Commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner.

(c) Every such transferring insurer shall notify the Commissioner of the details of the proposed transfer and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the Commissioner.

(May 24, 1996, D.C. Law 11-127, § 5, 43 DCR 1559; Mar. 24, 1998, D.C. Law 12-81, § 44(c), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4304.

Legislative history of Law 11-127. — For legislative history of D.C. Law 11-127, see Historical and Statutory Notes following § 31-1701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-1701.

§ 31-1705. Rulemaking.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, may issue rules and regulations to carry out the purpose of this chapter.

(May 24, 1996, D.C. Law 11-127, § 6, 43 DCR 1559.)

Prior Codifications. — 1981 Ed., § 35-4305.

Legislative history of Law 11-127. — For

legislative history of D.C. Law 11-127, see Historical and Statutory Notes following § 31-1701.

CHAPTER 18. REINSURANCE INTERMEDIARIES.

Sec.	Sec.
31-1801. Definitions.	31-1806. Required contract provisions; reinsurance intermediary-managers.
31-1802. Licensure.	31-1807. Prohibited acts.
31-1803. Required contract provisions; reinsurance intermediary-brokers.	31-1808. Duties of reinsurers utilizing the services of a reinsurance-intermediary-manager.
31-1804. Books and records; reinsurance intermediary brokers.	31-1809. Examination authority.
31-1805. Duties of insurers utilizing the services of a reinsurance intermediary-broker.	31-1810. Penalties and liabilities.

§ 31-1801. Definitions.

For the purposes of this chapter, the term:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "Controlling person" means any person, firm, association, or corporation who directly or indirectly has the power to direct, or cause to be directed, the management, control, or activities of the reinsurance intermediary.

(3) "District" means the District of Columbia.

(4) "Holding Company Act" means the Holding Company System Act of 1993, Chapter 7 of this title.

(5) "Insurer" means any person, firm, association, or corporation duly licensed in the District pursuant to the applicable provisions of District insurance law as an insurer.

(6) "Licensed producer" means an agent, broker, or reinsurance intermediary licensed pursuant to the applicable provision of insurance law.

(7) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in paragraphs (8) and (9) of this section.

(8) "Reinsurance intermediary-broker" ("RB") means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(9) "Reinsurance intermediary-manager" ("RM") means any person, firm, association, or corporation that has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office, and acts as an agent for the reinsurer whether known as a RM, manager, or other similar term. Notwithstanding the above, for the purposes of this chapter, the following persons shall not be considered a RM, with respect to such a reinsurer:

(A) An employee of the reinsurer;

(B) A United States manager of the United States branch of an alien reinsurer;

(C) An underwriting manager that, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to Chapter 7 of this title, and whose compensation is not based on the volume of premiums written; or

(D) The manager of a group, association, pool, or organization of insurers that engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or superintendent of insurance of the state in which the manager's principal business office is located.

(10) "Reinsurer" means any person, firm, association, or corporation duly licensed in the District pursuant to the applicable provisions of insurance law of the District as an insurer with the authority to assume reinsurance.

(11) "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this chapter.

(12) "Qualified United States financial institution" means an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States, any state, or the District;

(B) Is regulated, supervised, and examined by United States federal, state, or District authorities having regulatory authority over banks and trust companies; and

(C) Has been determined, by either the Mayor or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Mayor.

(Oct. 21, 1993, D.C. Law 10-47, § 2, 40 DCR 6093; May 16, 1995, D.C. Law 10-255, § 30, 41 DCR 5193.)

Section references. — This section is referred to in § 31-1803.

Prior Codifications. — 1981 Ed., § 35-3101.

Legislative history of Law 10-47. — Law 10-47, the "Reinsurance Intermediary Act of 1993," was introduced in Council and assigned Bill No. 10-126, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-92 and transmitted to both Houses of Congress for its review. D.C. Law 10-47 became effective on October 21, 1993.

Legislative history of Law 10-255. — Law 10-255, the "Technical Amendments Act of 1994," was introduced in Council and assigned

Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-47, the Reinsurance Intermediary Act of 1993, see Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

Editor's notes. — Mayor authorized to issue rules: Section 12 of D.C. Law 10-47 provided that the Mayor may, pursuant to subchapter I of Chapter 15 of Title 1 subchapter I of Chapter 5 of Title 2, 2001 Ed., issue rules to implement the provisions of this chapter.

§ 31-1802. Licensure.

(a) No person, firm, association, or corporation shall act as a reinsurance broker in the District if the reinsurance broker maintains an office either

directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation:

(1) In the District, unless the reinsurance broker is a licensed broker in the District; or

(2) In another state, unless the reinsurance broker is a licensed broker in the District or another state having a law substantially similar to this chapter or the reinsurance broker is licensed in the District as a nonresident reinsurance intermediary.

(b) No person, firm, association, or corporation shall act as a reinsurance manager:

(1) For a reinsurer domiciled in the District unless the reinsurance manager is a licensed broker in the District;

(2) In the District, if the reinsurance manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation in the District, unless the reinsurance manager is a licensed broker in the District; or

(3) In another state for a nondomestic insurer, unless the reinsurance manager is a licensed broker in the District or another state having a law substantially similar to this chapter or the person is licensed in the District as a nonresident reinsurance intermediary.

(c) The Mayor may require a reinsurance manager subject to subsection (b) of this section to:

(1) File a bond in an amount from an insurer acceptable to the Mayor for the protection of the reinsurer; and

(2) Maintain an errors and omissions policy in an amount acceptable to the Mayor.

(d)(1) The Mayor may issue a reinsurance intermediary license to any person, firm, association, or corporation that has complied with the requirements of this chapter. Such a license issued to a firm or association will authorize all the members of the firm or association, and any designated employees, to act as reinsurance intermediaries under the license, and all those persons shall be named in the application and any subsequent supplements. Such a license issued to a corporation shall authorize all of the officers, and any designated employees and directors, to act as reinsurance intermediaries on behalf of the corporation, and all those persons shall be named in the application and any subsequent supplements.

(2) If the applicant for a reinsurance intermediary license is a nonresident, such an applicant, as a condition precedent to receiving or holding a license, shall comply with the service of process provisions of § 31-202. Such a licensee shall promptly notify the Mayor in writing of every change in its designated agent for service of process, and no change shall become effective until acknowledged by the Mayor.

(e) The Mayor may refuse to issue a reinsurance intermediary license if, in his or her judgment, the applicant, anyone named on the application, or any member, principal, officer, or director of the applicant, is not trustworthy, or that any controlling person of such an applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for

revocation or suspension of such a license, or has failed to comply with any prerequisite for the issuance of such a license. Upon written request, the Mayor will furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to subchapter II of Chapter 5 of Title 2.

(f) Licensed attorneys at law of the District, when acting in their professional capacity, shall be exempt from this section.

(g) Any license issued pursuant to this section for a reinsurance intermediary shall be issued as a Financial Services endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(Oct. 21, 1993, D.C. Law 10-47, § 3, 40 DCR 6093; Apr. 26, 1994, D.C. Law 10-103, § 6(a), 41 DCR 1005; Mar. 21, 1995, D.C. Law 10-233, § 10, 42 DCR 24; Apr. 20, 1999, D.C. Law 12-261, § 2003(mm), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38, § 3(w), 50 DCR)

Section references. — This section is referred to in §§ 31-1805 and 31-1808.

Prior Codifications. — 1981 Ed., § 35-3102.

Effect of amendments. — D.C. Law 15-38, in subsec. (g), substituted “Financial Services endorsement to a basic business license under the basic” for “Class A Financial Services endorsement to a master business license under the master”.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 6(a) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(w) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

Legislative history of Law 10-47. — For legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 10-103. — Law 10-103, the “Insurance Omnibus Amendment Act of 1994,” was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and Feb-

ruary 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of 1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 12-261. — Law 12-261, the “Second Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 15-38. — For Law 15-38, see notes following § 31-1103.

§ 31-1803. Required contract provisions; reinsurance intermediary-brokers.

Transactions between a reinsurance broker and the insurer it represents shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

(1) The insurer may terminate the reinsurance broker's authority at any time.

(2) The reinsurance broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the reinsurance broker, and remit all funds due to the insurer within 30 days of receipt.

(3) All funds collected for the insurer's account will be held by the reinsurance broker in a fiduciary capacity in a bank which is a qualified United States financial institution as defined in § 31-1801.

(4) The reinsurance broker will comply with § 31-1804.

(5) The reinsurance broker will comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The reinsurance broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

(Oct. 21, 1993, D.C. Law 10-47, § 4, 40 DCR 6093.)

Prior Codifications. — 1981 Ed., § 35-3103.

legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 10-47. — For

1801.

§ 31-1804. Books and records; reinsurance intermediary brokers.

(a) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance broker, the reinsurance broker will keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes, or risks and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance broker;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the reinsurance broker including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including, but not limited to, premium and loss accounts; and

(11) When the reinsurance broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other

than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(b) The insurer will have access and the right to copy and audit all accounts and records maintained by the reinsurance broker related to its business in a form usable by the insurer.

(Oct. 21, 1993, D.C. Law 10-47, § 5, 40 DCR 6093.)

Section references. — This section is referred to in § 31-1803.

Prior Codifications. — 1981 Ed., § 35-3104.

Legislative history of Law 10-47. — For legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

§ 31-1805. Duties of insurers utilizing the services of a reinsurance intermediary-broker.

(a) An insurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance broker on its behalf unless the person is licensed as required by § 31-1802(a).

(b) An insurer may not employ an individual who is employed by a reinsurance broker with which it transacts business, unless the reinsurance broker is under common control with the insurer and subject to Chapter 7 of this title.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance broker with which it transacts business.

(Oct. 21, 1993, D.C. Law 10-47, § 6, 40 DCR 6093.)

Prior Codifications. — 1981 Ed., § 35-3105.

Legislative history of Law 10-47. — For

legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

§ 31-1806. Required contract provisions; reinsurance intermediary-managers.

Transactions between a reinsurance manager and the reinsurer it represents shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before a reinsurer assumes or cedes business through such a producer, a true copy of the approved contract shall be filed with the Mayor for approval. The contract shall, at a minimum, provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance manager. The reinsurer may immediately suspend the authority of the reinsurance manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The reinsurance manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the reinsurance manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the

reinsurance manager in a fiduciary capacity in a bank which is a qualified United States financial institution. The reinsurance manager may retain no more than 3 months estimated claims payments and allocated loss adjustment expenses. The reinsurance manager shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance manager, the reinsurance manager will keep a complete record for each transaction showing:

(A) The type of contract, limits, underwriting restrictions, classes, or risks, and territory;

(B) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(C) Reporting and settlement requirements of balances;

(D) Rate used to compute the reinsurance premium;

(E) Names and addresses of ceding insurers;

(F) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance manager;

(G) Related correspondence and memoranda;

(H) Proof of placement;

(I) Details regarding retrocessions handled by the RM, as permitted by § 31-1808(d), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(J) Financial records, including, but not limited to, premium and loss accounts; and

(K) When the reinsurance manager places a reinsurance contract on behalf of a ceding insurer:

(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance manager related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the reinsurance manager.

(7) The reinsurance manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The rates shall be set forth, as well as the terms and purposes of commissions, charges, and other fees which the reinsurance manager may levy against the reinsurer.

(9) If the contract permits the reinsurance manager to settle claims on behalf of the reinsurer:

(A) All claims will be reported to the reinsurer in a timely manner.

(B) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

- (i) Has the potential to exceed the lesser of an amount determined by the Mayor or the limit set by the reinsurer;
- (ii) Involves a coverage dispute;
- (iii) May exceed the reinsurance manager's claims settlement authority;
- (iv) Is open for more than 6 months; or
- (v) Is closed by payment of the lesser of an amount set by the Mayor or an amount set by the reinsurer.

(C) All claim files will be the joint property of the reinsurer and reinsurance manager. However, upon an order of liquidation of the reinsurer, the files shall become the sole property of the reinsurer or its estate; the reinsurance manager shall have reasonable access to and the right to copy the files on a timely basis.

(D) Any settlement authority granted to the reinsurance manager may be terminated for cause upon the reinsurer's written notice to the reinsurance manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the reinsurance manager, the interim profits will not be paid until 1 year after the end of each underwriting period for property business, and 5 years after the end of each underwriting period for casualty business, or a later period set by the Mayor for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to § 31-1806(c).

(11) The reinsurance manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically, at least semi-annually, conduct an on-site review of the underwriting and claims processing operations of the reinsurance manager.

(13) The reinsurance manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

(14) Within the scope of its actual or apparent authority, the acts of the reinsurance manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

(Oct. 21, 1993, D.C. Law 10-47, § 7, 40 DCR 6093; Feb. 27, 1996, D.C. Law 11-90, § 4(a), 42 DCR 7155.)

Prior Codifications. — 1981 Ed., § 35-3106.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4(a) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 5(a) of the Insurance Omnibus Emergency Amendment Act of

1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 4(a) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 10-47. — For legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 11-90. — Law

11-90, the "Insurance Omnibus Amendment Act of 1995," was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and

December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

§ 31-1807. Prohibited acts.

The reinsurance manager shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the reinsurance manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for retrocessions. These guidelines shall include a list of reinsurers with which the automatic agreements are in effect, and for each reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) Commit the reinsurer to participate in reinsurance syndicates;

(3) Appoint any broker without assuring that the broker is lawfully licensed to transact the type of reinsurance for which he or she is appointed;

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1% of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(5) Collect any payment from a retrocessionaire, or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

(6) Jointly employ an individual who is employed by the reinsurer unless the reinsurance manager is under common control with the reinsurer subject to Chapter 7 of this title; or

(7) Appoint a sub-reinsurance manager.

(Oct. 21, 1993, D.C. Law 10-47, § 8, 40 DCR 6093.)

Prior Codifications. — 1981 Ed., § 35-3107.

legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 10-47. — For

§ 31-1808. Duties of reinsurers utilizing the services of a reinsurance-intermediary-manager.

(a) A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance manager on its behalf unless the person is licensed as required by § 31-1802(b).

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance manager which the reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the Mayor.

(c) If a reinsurance manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss

reserves established for losses incurred and outstanding on business produced by the reinsurance manager. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance manager.

(e) Within 30 days of termination of a contract with a reinsurance manager, the reinsurer shall provide written notification of the termination to the Commissioner.

(f) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its reinsurance manager. This subsection shall not apply to relationships governed by Chapter 7 of this title.

(Oct. 21, 1993, D.C. Law 10-47, § 9, 40 DCR 6093; May 21, 1997, D.C. Law 11-268, § 10(bb), 44 DCR 1730.)

Section references. — This section is referred to in § 31-1806.

Prior Codifications. — 1981 Ed., § 35-3108.

Legislative history of Law 10-47. — For legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,”

was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

§ 31-1809. Examination authority.

(a) A reinsurance intermediary shall be subject to examination by the Mayor. The Mayor shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the Mayor.

(b) A reinsurance manager may be examined as if it were the reinsurer.

(Oct. 21, 1993, D.C. Law 10-47, § 10, 40 DCR 6093.)

Prior Codifications. — 1981 Ed., § 35-3109.

Legislative history of Law 10-47. — For

legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 35-3101.

§ 31-1810. Penalties and liabilities.

(a) If the Mayor determines that the reinsurer intermediary or any other person has not materially complied with this chapter, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the Mayor may order:

(1) For each separate violation, a penalty in an amount not exceeding \$10,000;

(2) Revocation or suspension of the producer’s license; and

(3) If it was found that because of material noncompliance the insurer has suffered any loss or damage, the Commissioner may maintain a civil action

brought by or on behalf of the insurer and its policyholders and creditors for recovery of compensatory damages for the benefit of the insurer and its policyholders and creditors, or other appropriate relief.

(b) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 13 of this title, and the receiver appointed under that order determines that the reinsurance intermediary or any other person has not materially complied with this chapter, or any regulation or order promulgated thereunder, and the insurer suffered any loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(c) Nothing contained in this section shall affect the right of the Mayor to impose any other penalties provided in District insurance law.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to those persons.

(Oct. 21, 1993, D.C. Law 10-47, § 11, 40 DCR 6093; Apr. 26, 1994, D.C. Law 10-103, § 6(b), 41 DCR 1005; Feb. 27, 1996, D.C. Law 11-90, §§ 4(b), 4(c), 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(bb), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-3110.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 6(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

For temporary (225 day) amendment of section, see § 4(b) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 5(b) and (c) of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 4(b) and (c) of the Insurance Omnibus Congressional Recess Emergency

Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 10-47. — For legislative history of D.C. Law 10-47, see Historical and Statutory Notes following § 31-1801.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-1802.

Legislative history of Law 11-90. — For legislative history of D.C. Law 11-90, see Historical and Statutory Notes following § 31-1806.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-1808.

CHAPTER 19. REQUIRED ANNUAL FINANCIAL STATEMENTS AND
PARTICIPATION IN THE NAIC INSURANCE REGULATORY INFORMATION
SYSTEM.

Sec.

31-1901. Filing requirements.

31-1902. Immunity.

Sec.

31-1903. Confidentiality.

31-1904. Revocation of Certificate of Authority.

§ 31-1901. Filing requirements.

(a) Every company or association authorized to transact insurance business in the District shall file annually with the Mayor, before March 1st of each year, a financial statement for the year ending December 31st immediately preceding on forms furnished by the Mayor. The Mayor may extend the time for filing the statement by any company for reasons which the Mayor shall deem sufficient. Such a statement shall be verified by the oath of the president and secretary of the company, or, in their absence, by 2 other principal officers. The Mayor shall annually, in the month of December, furnish to each of the companies and associations authorized to do insurance business in the District forms necessary for filing the annual financial statement required by this section. The forms shall conform substantially to the form of statement adopted by the National Association of Insurance Commissioners ("NAIC"). The filing of these statements shall be in accordance with the NAIC Accounting Practices and Procedures Manual. The Mayor shall have power to make modifications and additions in the financial statement forms as the Mayor may deem necessary to ascertain the condition and affairs of the company. The Mayor may also require that at least once in the month of March in each year a summary of the annual statement by the company be published in a daily newspaper in the District.

(b) Each domestic, foreign, and alien insurer authorized to transact insurance in the District shall annually, on or before March 1st of each year, file with the NAIC, and pay the fee established by the NAIC for filing, reviewing, or processing the information, a copy of its annual statement convention form, along with any additional filings prescribed by the Mayor for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the Mayor and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the Mayor shall also be filed with the NAIC.

(c) Foreign insurers domiciled in a state which has a law substantially similar to subsection (a) of this section shall be deemed in compliance with this section if they file their annual statements in compliance with that jurisdiction's law.

(Oct. 21, 1993, D.C. Law 10-42, § 2, 40 DCR 6020.)

Cross references. — Hospital and medical services corporation, additional required reports, see § 31-3513.

Hospital and medical services corporation, real property investments, see § 31-3510.

Hospital and medical services corporations, open enrollment statement, see § 31-3514.

Prior Codifications. — 1981 Ed., § 35-3401.

Legislative history of Law 10-42. — Law 10-42, the “Required Annual Financial Statements and Participation in the NAIC Insurance Regulatory Information System Act of 1993,” was introduced in Council and assigned Bill No. 10-129, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respec-

tively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-77 and transmitted to both Houses of Congress for its review. D.C. Law 10-42 became effective on October 21, 1993.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-42, the Required Annual Financial Statements and Participation in the NAIC Insurance Regulatory Information System Act of 1993, see Mayor’s Order 94-54, March 7, 1994 (41 DCR 1433).

Editor’s notes. — Mayor authorized to issue rules: Section 6 of D.C. Law 10-42 provided that the Mayor shall, pursuant to subchapter I of Chapter 15 of Title 1 [subchapter I of Chapter 5 of Title 2, 2001 Ed.], issue rules to implement the provisions of this chapter.

§ 31-1902. Immunity.

(a) In the absence of fraud, actual malice, or bad faith, members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others, including District employees, charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Mayor under the authority of this chapter, and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required by this chapter.

(b) Nothing in this section is intended to abrogate or modify in any way any common law or statutory privilege or immunity enjoyed by any person prior to this chapter.

(Oct. 21, 1993, D.C. Law 10-42, § 3, 40 DCR 6020.)

Prior Codifications. — 1981 Ed., § 35-3402.

Legislative history of Law 10-42. — For

legislative history of D.C. Law 10-42, see Historical and Statutory Notes following § 31-1901.

§ 31-1903. Confidentiality.

All financial analysis ratios and examination synopses and related information concerning insurance companies that are submitted to the Mayor by the NAIC Insurance Regulatory Information System are confidential and may not be disclosed by the Mayor or any member of the Department of Insurance, Securities, and Banking. This information shall not be subject to disclosure under the District of Columbia Freedom of Information Act or any other District law relating to disclosure of information.

(Oct. 21, 1993, D.C. Law 10-42, § 4, 40 DCR 6020; May 21, 1997, D.C. Law 11-268, § 10(dd), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(k), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-3403.

Effect of amendments. — D.C. Law 15-166 substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(k) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-42. — For legislative history of D.C. Law 10-42, see Historical and Statutory Notes following § 31-1901.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Se-

curities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

References in text. — The “District of Columbia Freedom of Information Act,” referred to in this section, is D.C. Law 1-96, codified at § 2-531 et seq.

§ 31-1904. Revocation of Certificate of Authority.

The Mayor may fine insurance companies or suspend, revoke, or refuse to renew the Certificate of Authority of any insurer failing to file its annual statement when due or within any extension of time which the Mayor, for good cause, may have granted.

(Oct. 21, 1993, D.C. Law 10-42, § 5, 40 DCR 6020.)

Prior Codifications. — 1981 Ed., § 35-3404.

Legislative history of Law 10-42. — For

legislative history of D.C. Law 10-42, see Historical and Statutory Notes following § 31-1901.

CHAPTER 20. RISK-BASED CAPITAL.

Sec.	Sec.
31-2001. Definitions.	nouncements; prohibition on use in ratemaking.
31-2002. RBC Reports.	
31-2003. Company Action Level Event.	31-2009. Supplemental provisions; rules; exemption.
31-2004. Regulatory Action Level Event.	
31-2005. Authorized Control Level Event.	31-2010. Foreign Insurers.
31-2006. Mandatory Control Level Event.	31-2011. Immunity.
31-2007. Hearings.	31-2012. Notices.
31-2008. Confidentiality; prohibition on an-	31-2013. Phase-in provision.

§ 31-2001. Definitions.

For the purposes of this chapter, the term:

- (1) "Adjusted RBC Report" means an RBC report that has been adjusted by the Commissioner in accordance with § 31-2002(g).
- (2) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.
- (3) "Corrective order" means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required.
- (4) "District" means the District of Columbia.
- (5) "Domestic insurer" means any insurance company domiciled in the District.
- (6) "Foreign insurer" means any insurance company which is licensed to do business in the District, but is not domiciled in the District.
- (7) "Life or health insurer" means any insurance company licensed to underwrite life or health insurance, or a licensed property and casualty insurer writing only accident and health insurance.
- (8) "NAIC" means the National Association of Insurance Commissioners.
- (9) "Negative trend" means, with respect to a life or health insurer, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the RBC Instructions.
- (10) "Property and casualty insurer" means any insurance company licensed to underwrite property and casualty insurance, but does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.
- (11) "RBC" means risk-based capital.
- (12) "RBC Instructions" means the RBC Report including risk-based capital instructions adopted by the NAIC, as such RBC Instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.
- (13) "RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:
 - (A) "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;
 - (B) "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;
 - (C) "Authorized Control Level RBC" means the number determined

under the risk-based capital formula in accordance with the RBC Instructions; and

(D) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

(14) "RBC Plan" means a comprehensive financial plan containing the elements specified in § 31-2003(b). If the Commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "Revised RBC Plan".

(15) "RBC Report" means the report required in § 31-2002.

(16) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus; and

(B) Such other items, if any, as the RBC Instructions may provide.

(17) "State" means any of the several states, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of Northern Mariana Islands.

(Apr. 9, 1997, D.C. Law 11-233, § 2, 44 DCR 765; Oct. 3, 2001, D.C. Law 14-28, § 2802, 48 DCR 6981; June 11, 2004, D.C. Law 15-166, § 4(l)(1), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4601.

Effect of amendments. — D.C. Law 14-28, in par. (1), substituted "31-2002(g)" for "31-2002(c)".

D.C. Law 15-166, in par. (2), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Emergency legislation. — For temporary (90 day) amendment of section, see § 2602 of Fiscal Year 2002 Budget Support Emergency Act of 2001 (D.C. Act 14-124, August 3, 2001, 48 DCR 7861).

For temporary (90 day) amendment of section, see § 4(l)(1) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-233. — Law 11-233, the "Risk-Based Capital Act of 1996," was introduced in Council and assigned Bill

No. 11-237, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-493 and transmitted to both Houses of Congress for its review. D.C. Law 11-233 became effective on April 9, 1997.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 14-28. — Law 14-28, the "Fiscal Year 2002 Budget Support Act of 2001", was introduced in Council and assigned Bill No. 14-144, which was referred to the Committee Of the Whole. The Bill was adopted on first and second readings on May 1, 2001, and June 5, 2001, respectively. Signed by the Mayor on June 29, 2001, it was assigned Act No. 14-85 and transmitted to both Houses of Congress for its review. D.C. Law 14-28 became effective on October 3, 2001.

§ 31-2002. RBC Reports.

(a) Every domestic insurer shall, on or prior to each March 1 ("filing date"), prepare and submit to the Commissioner a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC Instructions. In addition, every domestic insurer shall file its RBC Report:

(1) With the NAIC in accordance with the RBC Instructions; and

(2) With the commissioner in any state in which the insurer is authorized to do business, if the commissioner has notified the insurer of its request in

writing, in which case the insurer shall file its RBC Report not later than the later of:

(A) Fifteen days from the receipt of notice to file its RBC Report with that state; or

(B) The filing date.

(b) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account, and may be adjusted for the covariance between:

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and such other relevant risks as are set forth in the RBC Instructions;

(c) Factors set forth in subsection (b)(1) through (4) of this section shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(d) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account and may adjust for the covariance between:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC Instructions;

(e) The factors set forth in subsection (d)(1) through (4) of this section shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(f) An excess of capital over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules, and instructions referenced in this chapter is desirable in the business of insurance. Insurers should maintain capital above the RBC Levels required by this chapter.

(g) If a domestic insurer files an RBC Report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment.

(Apr. 9, 1997, D.C. Law 11-233, § 3, 44 DCR 765.)

Section references. — This section is referred to in §§ 31-2001 and 31-2010.

Prior Codifications. — 1981 Ed., § 35-4602.

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2003. Company Action Level Event.

(a) For the purposes of this chapter, the term "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer which indicates that:

(A) The insurer's total adjusted capital is greater than or equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

(B) If a life or health insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC, but less than the product of its Authorized Control Level RBC and 2.5 and has a negative trend; or

(C) If licensed as a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC, but less than the product of its Authorized Control Level RBC and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions;

(2) The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in paragraph (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under § 31-2007; or

(3) If, pursuant to § 31-2007, an insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the Commissioner an RBC Plan which shall:

(1) Identify the conditions which contribute to the Company Action Level Event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event;

(3) Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) The RBC Plan shall be submitted to the Commissioner within 45 days of the Company Action Level Event; or if the insurer challenges an Adjusted RBC Report pursuant to § 31-2007, within 45 days after notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner,

unsatisfactory. If the Commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner within 45 days after the notification from the Commissioner; or if the insurer challenges the notification from the Commissioner under § 31-2007, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under § 31-2007, specify in the notification that the notification constitutes a Regulatory Action Level Event as defined in § 31-2004.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has a RBC provision substantially similar to § 31-2008(a); and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

(B) The date on which the RBC Plan or Revised RBC Plan is filed under § 31-2003(c) and (d).

(Apr. 9, 1997, D.C. Law 11-233, § 4, 44 DCR 765; Mar. 14, 2012, D.C. Law 19-103, § 3, 59 DCR 432.)

Section references. — This section is referred to in §§ 31-2001, 31-2004, and 31-2013.

Prior Codifications. — 1981 Ed., § 35-4603.

Effect of amendments. — D.C. Law 19-103, in subsec. (a)(1), deleted "and" from the end of subpar. (A), substituted "; or" for a period the end of subpar. (B), and added subpar. (C).

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

Legislative history of Law 19-103. — For history of Law 19-103, see notes under § 31-3931.03.

§ 31-2004. Regulatory Action Level Event.

(a) For the purposes of this chapter, the term "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC, but less than its Regulatory Action Level RBC;

(2) The notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection,

provided the insurer does not challenge the Adjusted RBC Report under § 31-2007;

(3) If, pursuant to § 31-2007, the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

(5) The failure of the insurer to submit an RBC Plan to the Commissioner within the time period set forth in § 31-2003(c);

(6) Notification by the Commissioner to the insurer that:

(A) The RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

(B) Such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under § 31-2007;

(7) If, pursuant to § 31-2007, the insurer challenges a determination by the Commissioner under paragraph (6) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

(8) Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event in accordance with its RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under § 31-2007; or

(9) If, pursuant to § 31-2007, the insurer challenges a determination by the Commissioner under paragraph (8) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge.

(b) In the event of a Regulatory Action Level Event, the Commissioner shall:

(1) Require the insurer to prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

(2) Perform such examination or analysis, as the Commissioner deems necessary, of the assets, liabilities, and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

(3) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the Commissioner shall determine are required ("Corrective Order").

(c) In determining corrective actions, the Commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions. The RBC Plan or Revised RBC Plan shall be submitted:

(1) Within 45 days after the occurrence of the Regulatory Action Level Event;

(2) If the insurer challenges an Adjusted RBC Report pursuant to § 31-2007 and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge; or

(3) If the insurer challenges a Revised RBC Plan pursuant to § 31-2007 and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities, and operations of the insurer, and formulate the Corrective Order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the Commissioner.

(Apr. 9, 1997, D.C. Law 11-233, § 5, 44 DCR 765.)

Section references. — This section is referred to in §§ 31-2003, 31-2005, and 31-2013.

Prior Codifications. — 1981 Ed., § 35-4604.

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2005. Authorized Control Level Event.

(a) For the purposes of this chapter, the term "Authorized Control Level Event" means any of the following events:

(1) The filing of an RBC Report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC, but less than its Authorized Control Level RBC;

(2) The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under § 31-2007;

(3) If, pursuant to § 31-2007, the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order (provided the insurer has not challenged the corrective order under § 31-2007); or

(5) If the insurer has challenged a corrective order under § 31-2007 and the Commissioner has, after a hearing, rejected the challenge or modified the Corrective Order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an Authorized Control Level Event with respect to an insurer, the Commissioner shall:

(1) Take such actions as are required under § 31-2004 regarding an insurer with respect to which a Regulatory Action Level Event has occurred; or

(2) If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Chapter 13 of this title. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 13 of this title, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Chapter 13 of this title. In the event the Commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to such projections as are afforded to insurers under the provisions of Chapter 13 of this title pertaining to summary proceedings.

(Apr. 9, 1997, D.C. Law 11-233, § 6, 44 DCR 765.)

Section references. — This section is referred to in § 31-2013.

Prior Codifications. — 1981 Ed., § 35-4605.

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2006. Mandatory Control Level Event.

(a) For the purposes of this chapter, the term “Mandatory Control Level Event” means any of the following events:

(1) The filing of an RBC Report which indicates that the insurer’s total adjusted capital is less than its Mandatory Control Level RBC;

(2) Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, provided the insurer does not challenge the Adjusted RBC Report under § 31-2007; or

(3) If, pursuant to § 31-2007, the insurer challenges an Adjusted RBC Report that indicates the event in paragraph (1) of this subsection, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer’s challenge.

(b) In the event of a Mandatory Control Level Event:

(1) With respect to a life insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 13 of this title. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 13 of this title, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Chapter 13 of this title. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of Chapter 13 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(2) With respect to a property and casualty insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 13 of this title, or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 13 of this title, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Chapter 13 of this title. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to the protections of Chapter 13 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

(Apr. 9, 1997, D.C. Law 11-233, § 7, 44 DCR 765.)

Section references. — This section is referred to in § 31-2013.

Prior Codifications. — 1981 Ed., § 35-4606.

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2007. Hearings.

(a) The insurer shall have a right to a hearing, at which the insurer may challenge any of the following determinations or actions by the Commissioner:

(1) Notification to an insurer by the Commissioner of an Adjusted RBC Report;

(2) Notification to an insurer by the Commissioner that:

(A) The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

(B) Such notification constitutes a Regulatory Action Level Event with respect to such insurer;

(3) Notification to any insurer by the Commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

(4) Notification to an insurer by the Commissioner of a Corrective Order with respect to the insurer.

(b) The insurer shall notify the Commissioner of its request for a hearing within 5 days after the notification by the Commissioner under subsection (a) of this section. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's request.

(Apr. 9, 1997, D.C. Law 11-233, § 8, 44 DCR 765.)

Section references. — This section is referred to in §§ 31-2003, 31-2004, 31-2005, and 31-2006.

Prior Codifications. — 1981 Ed., § 35-4607.

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2008. Confidentiality; prohibition on announcements; prohibition on use in ratemaking.

(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any Corrective Order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer that are in the possession or control of the Department of Insurance, Securities, and Banking shall be confidential and privileged; shall not be subject to subchapter II of Chapter 5 of Title 2; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in a private civil action; provided, that the Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. This information is also exempt from any applicable freedom of information law, public records law, public records disclosure law, or other similar statute.

(a-1) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not be permitted or required to testify in a private civil action concerning confidential documents, materials, or other information subject to subsection (a) of this section.

(a-2) To assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to subsection (a) of this section, with other state, federal, and international regulatory agencies; with the National Association of Insurance Commissioners, including its affiliates and subsidiaries; and with state, federal and international law enforcement authorities; provided, that the recipient agrees, and has the legal authority, to maintain the confidentiality and privileged status of the documents, materials, or other information;

(2) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information, from the National Association of Insurance Commissioners, and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; or

(3) May enter into agreements governing the sharing and use of information consistent with this section.

(a-3) No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a-2) of this section. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(b) Except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurers' RBC Levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(c) The RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans and Revised RBC Plans shall not be used by the Commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

(Apr. 9, 1997, D.C. Law 11-233, § 9, 44 DCR 765; Oct. 21, 2000, D.C. Law 13-191, § 4, 47 DCR 7311; June 11, 2004, D.C. Law 15-166, § 4(l)(2), 51 DCR 2817.)

Section references. — This section is referred to in § 31-2003.

Prior Codifications. — 1981 Ed., § 35-4608.

Effect of amendments. — D.C. Law 13-191 rewrote subsec. (a) and added subsecs. (a-1) to (a-3). Prior to amendment, subsec. (a) provided: "(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or report of any examination or analysis of an insurer performed pursuant hereto and any Corrective Order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the Commissioner constitute infor-

mation that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the Commissioner. This information shall not be made public or be subject to subpoena, other than by the Commissioner and then only for the purpose of enforcement actions taken by the Commissioner pursuant to this chapter or any other provision of the insurance laws of the District. This information is also exempt from any applicable freedom of information law, public records law, public records disclosure law, or other similar statute."

D.C. Law 15-166, in subsec. (a), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(1)(2) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

Legislative history of Law 13-191. — Law 13-191, the “Insurer Confidentiality and Information Sharing Amendment Act of 2000,” was

introduced in Council and assigned Bill No. 13-706, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-419 and transmitted to both Houses of Congress for its review. D.C. Law 13-191 became effective on October 21, 2000.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-2009. Supplemental provisions; rules; exemption.

(a) The provisions of this chapter are supplemental to any other provisions of the laws of the District, and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including, but not limited to, Chapter 13 and Chapter 21 of this title.

(b) The Commissioner may adopt reasonable rules necessary for the implementation of this chapter.

(c) The Commissioner may exempt from the application of this chapter any insurer which;

- (1) Writes direct business only in the District;
- (2) Writes direct annual premiums of \$1 million or less; and
- (3) Assumes no reinsurance in excess of 5% of direct premium written.

(Apr. 9, 1997, D.C. Law 11-233, § 10, 44 DCR 765.)

Prior Codifications. — 1981 Ed., § 35-4609.

Legislative history of Law 11-233. — For

legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

§ 31-2010. Foreign Insurers.

(a) Any foreign insurer, upon the written request of the Commissioner, shall submit to the Commissioner an RBC Report as of the end of the calendar year just ended on the later of:

(1) The date an RBC Report would be required to be filed by a domestic insurer under this chapter; or

(2) Fifteen days after the request is received by the foreign insurer.

(b) Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC Plan that is filed with the commissioner of any other state.

(c) In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event, with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC statute is in force in that state under the provisions of this chapter), if the insurance commissioner or similar authority of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in the manner specified under that state’s RBC statute (or, if no RBC statute is in force in that state, under § 31-2002), the Commissioner may

require the foreign insurer to file an RBC Plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in the District.

(d) In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Superior Court permitted under Chapter 13 of this title with respect to the liquidation of property of foreign insurers found in the District, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

(Apr. 9, 1997, D.C. Law 11-233, § 11, 44 DCR 765.)

Prior Codifications. — 1981 Ed., § 35-4610. legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

Legislative history of Law 11-233. — For

§ 31-2011. Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, the Commissioner or the Department of Insurance, Securities, and Banking or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

(Apr. 9, 1997, D.C. Law 11-233, § 12, 44 DCR 765; June 11, 2004, D.C. Law 15-166, § 4(l)(3), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4611.

Effect of amendments. — D.C. Law 15-166 substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(l)(3) of Consolidation of Financial Services Emergency

Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-233. — For legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-2012. Notices.

All notices by the Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer’s receipt of such notice.

(Apr. 9, 1997, D.C. Law 11-233, § 13, 44 DCR 765.)

Prior Codifications. — 1981 Ed., § 35-4612. legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

Legislative history of Law 11-233. — For

§ 31-2013. Phase-in provision.

(a) For RBC Reports required to be filed by life insurers with respect to 1993, the following requirements shall apply in lieu of the provisions of §§ 31-2003, 31-2004, 31-2005, and 31-2006:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the Commissioner shall take no regulatory action hereunder.

(2) In the event of an Regulatory Action Level Event under § 31-2004(a)(1), (2), or (3), the Commissioner shall take the actions required under § 31-2003.

(3) In the event of an Regulatory Action Level Event under § 31-2004(a)(4), (5), (6), (7), (8), or (9) or an Authorized Control Level Event, the Commissioner shall take the actions required under § 31-2004 with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the Commissioner shall take the actions required under § 31-2005 with respect to the insurer.

(b) For RBC Reports required to be filed by property and casualty insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of §§ 31-2003, 31-2004, 31-2005, and 31-2006:

(1) In the event of a Company Action Level Event with respect to a domestic insurer, the Commissioner shall take no regulatory action hereunder.

(2) In the event of an Regulatory Action Level Event under § 31-2004(a)(1), (2), or (3) the Commissioner shall take the actions required under § 31-2003.

(3) In the event of an Regulatory Action Level Event under § 31-2004(a)(4), (5), (6), (7), (8), or (9) or an Authorized Control Level Event, the Commissioner shall take the actions required under § 31-2004 with respect to the insurer.

(4) In the event of a Mandatory Control Level Event with respect to an insurer, the Commissioner shall take the actions required under § 31-2005 with respect to the insurer.

(Apr. 9, 1997, D.C. Law 11-233, § 14, 44 DCR 765.)

Prior Codifications. — 1981 Ed., § 35-4613.

Legislative history of Law 11-233. — For

legislative history of D.C. Law 11-233, see Historical and Statutory Notes following § 31-2001.

CHAPTER 21. STANDARDS TO IDENTIFY INSURANCE COMPANIES
DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION.

Sec.

31-2101. Standards for determining insurance companies in hazardous financial condition.

Sec.

31-2102. Corrective actions.

31-2103. Judicial review.

§ 31-2101. Standards for determining insurance companies in hazardous financial condition.

(a) In order to determine whether the continued operation of any insurer transacting an insurance business in the District of Columbia might be deemed to be hazardous to the policyholders, creditors, or the general public, the Mayor may consider the following standards, either singly or in combination of 2 or more:

(1) Adverse findings reported in financial condition and market conduct examination reports;

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports;

(3) The ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus;

(4) The insurer's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;

(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(6) The insurer's operating loss in the last 12-month period or any shorter period of time, including, but not limited to, net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than 50% of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(7) Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation;

(8) Contingent liabilities, pledges, or guaranties which, either individually or collectively, involve a total amount which in the opinion of the Mayor may affect the solvency of the insurer;

(9) Whether any controlling person of an insurer is delinquent in the transmitting to, or payment of, net premiums to such an insurer;

(10) The age and collectibility of receivables;

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such a position;

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

(13) Whether management of an insurer either has filed any false or misleading sworn financial statement, has released any false or misleading financial statement to lending institutions or to the general public, has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

(14) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; or

(15) Whether the company has experienced or will experience in the foreseeable future cash flow or liquidity problems.

(b) For the purposes of making a determination of an insurer's financial condition under this chapter, the Mayor may:

(1) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(2) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

(3) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; and

(4) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

(Oct. 21, 1993, D.C. Law 10-43, § 2, 40 DCR 6023.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-3501.

Legislative history of Law 10-43. — Law 10-43, the "Standards to Identify Insurance Companies Deemed to Be in Hazardous Financial Condition Act of 1993," was introduced in Council and assigned Bill No. 10-130, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act

No. 10-78 and transmitted to both Houses of Congress for its review. D.C. Law 10-43 became effective on October 21, 1993.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-43, the Standards to Identify Insurance Companies Deemed to Be in Hazardous Financial Condition Act of 1993: See Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

Editor's notes. — Mayor authorized to issue rules: Section 5 of D.C. Law 10-43 provided that the Mayor shall, pursuant to subchapter I of Chapter 15 of Title 1 [subchapter I of Chapter 5 of Title 2, 2001 Ed.], issue rules to implement the provisions of this chapter.

§ 31-2102. Corrective actions.

(a) If the Mayor determines that the continued operation of the insurer licensed to transact business in the District of Columbia may be hazardous to the policyholders or the general public, the Mayor may, upon his or her determination, issue an order requiring the insurer to:

- (1) Reduce the total amount of present and potential liability for policy benefits by reinsurance;
 - (2) Reduce, suspend, or limit the volume of business being accepted or renewed;
 - (3) Reduce general insurance and commission expenses by specified methods;
 - (4) Increase the insurer's capital and surplus;
 - (5) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;
 - (6) File reports in a form acceptable to the Mayor concerning the market value of an insurer's assets;
 - (7) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Mayor deems necessary;
 - (8) Document the adequacy of premium rates in relation to the risks insured; or
 - (9) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on a form promulgated by the Mayor.
- (b) If the insurer is a foreign insurer, the Mayor's order under subsection (a) of this section may be limited to the extent provided by statute.
- (c) Any insurer subject to an order under subsection (a) of this section may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant to § 2-509. The notice of hearing shall state the time and place of hearing, and the conduct, condition, or ground upon which the Mayor based the order. Unless mutually agreed between the Mayor and the insurer, the hearing shall occur not less than 10 days nor more than 30 days after notice is served and shall be held in the District of Columbia. The Mayor shall hold all hearings under this section privately, unless the insurer requests a public hearing, in which case the hearing shall be public.
- (d) The procedures and remedies set forth in this chapter do not in any way supercede or limit the authority of the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] to take over a company or to revoke or suspend its certificate of authority pursuant to Chapter 11 of this title, Chapter 25 of this title, or Chapter 43 of this title.

(Oct. 21, 1993, D.C. Law 10-43, § 3, 40 DCR 6023; Apr. 26, 1994, D.C. Law 10-103, § 7(a), 41 DCR 1005; May 21, 1997, D.C. Law 11-268, § 10(ee), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-3502.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(a) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-43. — For legislative history of D.C. Law 10-43, see His-

torical and Statutory Notes following § 31-2101.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and Feb-

ruary 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill

No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

§ 31-2103. Judicial review.

Any order or decision of the Mayor shall be subject to review in accordance with § 2-510, at the request of any person suffering a legal wrong or whose interests are adversely affected or aggrieved by the order or decision of the Mayor.

(Oct. 21, 1993, D.C. Law 10-43, § 4, 40 DCR 6023.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-3503.

Legislative history of Law 10-43. — For legislative history of D.C. Law 10-43, see Historical and Statutory Notes following § 31-2101.

CHAPTER 22. STATE OF ENTRY FOR NON-U.S. INSURERS.

Sec.

31-2201. Definitions.

31-2202. Authorization of entry.

31-2203. Maintenance of trust account.

31-2204. Requirements for trust agreement.

31-2205. Reporting requirements for U.S. Branches of non-U.S. insurers.

Sec.

31-2206. Additional requirements for U.S. Branch license.

31-2207. Authority of the Commissioner.

§ 31-2201. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(1A) "District" means the District of Columbia.

(2) "Non-U.S. insurer" means an insurer organized under the laws of a foreign country.

(3) Repealed.

(4) "United States Branch" or "U.S. Branch" means the business unit through which business is transacted within the United States by a non-U.S. insurer and the assets and liabilities of the insurer within the United States pertaining to such business.

(May 24, 1996, D.C. Law 11-128, § 2, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(m), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4401.

Effect of amendments. — D.C. Law 15-166, in par. (1), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(m) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-128. — Law 11-128, the "Insurance State of Entry Act of 1996," was introduced in Council and assigned Bill No. 11-391, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on February 6, 1996, and March 5, 1996, respectively. Signed by the Mayor on March 15, 1996, it was assigned Act No. 11-235 and transmitted to both Houses of Congress for its review. D.C. Law 11-128 became effective on May 24, 1996.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-2202. Authorization of entry.

(a) A non-U.S. insurer may use the District as a state of entry to transact insurance in the United States through a U.S. branch by:

(1) Qualifying as an insurer licensed to do business in the District; and

(2) Establishing a trust account, pursuant to a trust agreement approved by the Commissioner, with a U.S. bank approved by the Commissioner in an

amount at least equal to the minimum capital and surplus required to be maintained by a domestic insurer licensed to do the same kind of insurance.

(b) Before authorizing the entry through the District of a U.S. branch of any non-U.S. insurer, the Commissioner shall require the non-U.S. insurer, in addition to the requirements of § 31-2204 and any other requirement of the insurance law, to submit:

(1) A copy of its charter and by-laws, if any, currently in force, and such other documents necessary to show the kinds of business which it is empowered to do in its domiciliary jurisdiction, attested to as accurate and complete by the insurance supervisory official in its home jurisdiction, and a full statement, subscribed and affirmed as true under the penalties of perjury by 2 officers or equivalent responsible representatives in such manner as the Commissioner shall prescribe, of its financial conditions as of the close of its latest fiscal year, showing its assets, liabilities, income disbursements, business transacted, and other facts required to be shown in its annual statement, as reported to the insurance supervisory official in its home jurisdiction, and an English language translation, as necessary, of any of the documents required herein; and

(2) To an examination of the insurer's affairs at its principal office within the United States. However, the Commissioner may instead accept a report of the insurance supervisory official of the insurer's home jurisdiction.

(May 24, 1996, D.C. Law 11-128, § 3, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4402.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see Historical and Statutory Notes following § 31-2201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2201.

§ 31-2203. Maintenance of trust account.

The assets in the trust account shall be known as trustee assets and shall at all times be in an amount equal to the U.S. branch's reserves and other liabilities plus the minimum capital and surplus required to be maintained by a domestic insurer licensed to do the same kind of insurance.

(May 24, 1996, D.C. Law 11-128, § 4, 43 DCR 1562.)

Section references. — This section is referred to in §§ 31-2204 and 31-2306.

Prior Codifications. — 1981 Ed., § 35-4403.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see Historical and Statutory Notes following § 31-2201.

§ 31-2204. Requirements for trust agreement.

(a) The deed of trust and all amendments thereto shall be authenticated in such form and manner as the Commissioner may prescribe and shall not be effective unless approved by the Commissioner upon a finding that:

(1) A deed of trust or its amendments are sufficient in form and in conformity with law;

(2) The trustee or trustees are eligible as such; and

(3) The deed of trust is adequate to protect the interest of the beneficiaries of the trust.

(b) If at any time the Commissioner finds, after reasonable notice and hearing, that the requisites for the approval no longer exist, the Commissioner may withdraw approval.

(c) The Commissioner may from time to time approve modifications of, or variations in any deed of trust, which in the Commissioner's judgement are not prejudicial to the interest of the people of the District or the United States policyholders and creditors of the U.S. Branch.

(d) The deed of trust shall contain provisions which:

(1) Vest legal title to trustee assets in the trustees and their successors lawfully appointed;

(2) Require that all assets deposited in the trust shall be continuously kept within the United States;

(3) Provide for substitution of a new trustee or trustees in case of a vacancy by death, resignation, or otherwise, subject to the approval of the Commissioner;

(4) Require that the trustee or trustees shall continuously maintain a record at all times sufficient to identify the assets of such fund;

(5) Require that the trustee assets shall consist of cash or investments eligible for investment of the funds of domestic insurers and accrued interest thereon if collectable by the trustee;

(6) Require that the trust shall be for the exclusive benefit, security, and protection of the policyholders, or policyholders and creditors, of the U.S. Branch in the United States and that it shall be maintained as long as there is outstanding any liability of the non-U.S. insurer arising out of its insurance transactions in the United States; and

(7) Provide, in substance, that no withdrawals of assets, other than income as specified in subsection (e) of this section shall be made or permitted by the trustee or trustees without the approval of the Commissioner except to:

(A) Make deposits required by law in any state for the security or benefit of all policyholders, or policyholders and creditors, of the U.S. Branch in the United States;

(B) Substitute other assets permitted by law and at least equal in value and quality to those withdrawn upon the specific written direction of the United States manager when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors; or

(C) Transfer such assets to an official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

(e) The deed of trust may provide that income, earnings, dividends, or interest accumulations of the assets of the fund may be paid over to the United States manager of the U.S. branch upon request, provided that the total trustee assets shall not thereby be less than the amount required to be maintained pursuant to § 31-2203.

(f) Upon withdrawal of trusted assets deposited in another state in which the insurer is authorized to do business, it shall be sufficient if the deed of trust requires similar written approval of the insurance supervising official of that state in lieu of approval of the Commissioner provided that the total trusted assets shall not thereby be less than the amount required to be maintained pursuant to § 31-2203. In all such cases, the U.S. Branch shall notify the Commissioner in writing of the nature and extent of the withdrawal.

(g) The Commissioner may from time to time:

(1) Make examinations of the trusted assets of any authorized U.S. Branch at the insurer's expense; and

(2) Require the trustee or trustees to file a statement, in such form as the Commissioner may prescribe, certifying the assets of the trust fund and the amounts thereof.

(h) Refusal or neglect of any trustee to comply with the requirements of this section shall be grounds for the revocation of the insurer's license or the liquidation of its United States Branch.

(May 24, 1996, D.C. Law 11-128, § 5, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(c), 45 DCR 745.)

Section references. — This section is referred to in §§ 31-2202, 31-2205, and 31-2306.

Prior Codifications. — 1981 Ed., § 35-4404.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see His-

torical and Statutory Notes following § 31-2201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2201.

§ 31-2205. Reporting requirements for U.S. Branches of non-U.S. insurers.

(a) In addition to other requirements of this chapter, every authorized U.S. Branch shall, not later than the first day of March in each year and 45 days after the end of each of the first 3 calendar-year quarters, file the following with the Commissioner and with the National Association of Insurance Commissioners ("NAIC"):

(1) Annual and quarterly statements of the business transacted within the United States and the assets held by or for it within the United States for the protection of policy holders and creditors within the United States, and of the liabilities incurred against such assets. The forms shall not contain any statement in regard to its assets and business elsewhere. The statements shall be in the same format required of an insurer domiciled in the United States Branch's state of entry state and licensed to write the same kinds of insurance; and

(2) A statement of trusted surplus, in such form as the Commissioner may prescribe, as of the end of the same period covered by the statement filed pursuant to paragraph (1) of this subsection. The aggregate value of the insurer's general state deposits and trusted assets deposited with a trustee in compliance with § 31-2204, plus accrued investment income thereon where such interest is collected by the states for trustees, less the aggregate net amount of all of its reserves and other liabilities in the United States as

determined in accordance with this section, shall be known as its trusted surplus in the United States. In determining the net amount of the U.S. Branch's liabilities in the United States to be reported in the statement of trusted surplus, the U.S. Branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statements as follows:

(A) Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement; and

(B) Deduct:

(i) Unearned premiums on agent's balances or uncollected premiums not more than 90 days past due;

(ii) Reinsurance on losses with authorized insurers, less unpaid reinsurance premiums;

(iii) Reinsurance recoverable on paid losses from unauthorized insurers that are included as an asset in the annual statement, but only to the extent a liability for such unauthorized recoverables is included in the liabilities report in the trusted surplus statement;

(iv) Special state deposits held for the exclusive benefit of policyholders, or policyholders and creditors, of any particular state not exceeding net liabilities reports for that state;

(v) Secured accrued retrospective premiums;

(vi) If a life insurer, the amount of its policy loans to policyholders within the United States, not exceeding the amount of legal reserve required on each such policy, and the net amount of uncollected and deferred premiums; and

(vii) Any other nontrusted asset which the Commissioner determines secures liabilities in a substantially similar manner; and

(3) Any additional information that the Commissioner may require relating to the total business or assets, or any portion thereof, of the non-U.S. insurer.

(b) The annual statement and trusted surplus statement shall be signed and verified by the United States manager, attorney-in-fact, or a duly empowered assistant United States manager of the U.S. Branch. The items of securities and other property held under trust deeds shall be certified in the trusted surplus statement by the United States trustee or trustees.

(c) Every report on examination of a U.S. Branch shall include a trusted surplus statement as of the date of examination in addition to the general statement of the financial condition of the U.S. Branch.

(May 24, 1996, D.C. Law 11-128, § 6, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(d), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4405.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see Historical and Statutory Notes following § 31-2201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2201.

§ 31-2206. Additional requirements for U.S. Branch license.

(a) Before issuing any new or renewal license to any U.S. Branch, the Commissioner may require satisfactory proof, either in the non-U.S. insurer's charter or by an agreement evidenced by a duly certified resolution of its board of directors, or otherwise as the Commissioner may require, that the insurer will not engage in any insurance business in contravention of the provisions of this chapter or not authorized by its charter.

(b) The Commissioner shall issue a renewal license to any U.S. Branch if satisfied, by such proof as required, that the insurer is not delinquent with respect to any requirement imposed by this chapter and that its continuance in business in the District will not be hazardous or prejudicial to the best interest of the people of the District.

(c) No U.S. Branch shall be licensed to do in the District any kind of insurance business, or any combination of kinds of insurance business, which are not permitted to be done by domestic insurers licensed under the provisions of this chapter. No U.S. Branch shall be authorized to do an insurance business in the District if it does anywhere within the United States any kind of business other than an insurance business and the business necessarily or properly incidental to the kinds of insurance business which it is authorized to do in the District.

(d) Except as otherwise specifically provided, no U.S. Branch, entering through the District or another state, shall be or continue to be authorized to do an insurance business in the District if it fails to comply substantially with any requirement or limitation of this chapter applicable to similar domestic insurers hereafter organized, which in the judgement of the Commissioner is reasonably necessary to protect the interest of the policyholders.

(e) No U.S. Branch that does outside of the District any kind or combination of kinds of insurance business not permitted to be done in the District by similar domestic insurers hereafter organized shall be or continue to be authorized to do an insurance business in the District, unless in the judgement of the Commissioner the doing of such kind or combination of kinds of insurance business will not be prejudicial to the best interest of the people of the District.

(f) No U.S. Branch shall be, or continue to be, authorized to do an insurance business in the District if it fails to keep full and correct entries of its transactions, which shall at all times be open to the inspection of persons invested by law with the rights of inspection and be maintained in its principal office within the District.

(May 24, 1996, D.C. Law 11-128, § 7, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(e), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4406.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see His-

torical and Statutory Notes following § 31-2201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-2201.

§ 31-2207. Authority of the Commissioner.

Whenever it appears to the Commissioner from any annual or quarterly statement, trustee surplus statement, or any other report that a U.S. Branch's trustee surplus is reduced below minimum capital and surplus required to be maintained by a domestic insurer licensed to transact the same kinds of insurance, the Commissioner may proceed against the insurer pursuant to the provisions of District law as an insurer whose condition is such that its further transaction of business in the United States will be hazardous to its policyholders, its creditors, or the public in the United States.

(May 24, 1996, D.C. Law 11-128, § 8, 43 DCR 1562; Mar. 24, 1998, D.C. Law 12-81, § 45(f), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4407.

Legislative history of Law 11-128. — For legislative history of D.C. Law 11-128, see Historical and Statutory Notes following § 31-2201.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2201.

CHAPTER 22A. UNFAIR INSURANCE TRADE PRACTICES.

Sec.	Sec.
31-2231.01. Definitions.	prohibited; property, casualty, and surety insurance.
31-2231.02. General prohibition.	31-2231.14. Interlocking ownerships, management.
31-2231.03. Misrepresentations and false advertising of insurance policies.	31-2231.15. Unfair financial planning practices; an insurance agent or broker.
31-2231.04. False information and advertising generally.	31-2231.16. Failure to provide claims history.
31-2231.05. Defamation.	31-2231.17. Unfair claim settlement practices.
31-2231.06. Boycott, coercion, and intimidation.	31-2231.18. Failure to maintain complaint handling procedures.
31-2231.07. Illegal dealing in premiums; excess charges for insurance.	31-2231.19. Misrepresentation in insurance application.
31-2231.08. False statements and entries.	31-2231.20. Favored agent or insurer; coercion of debtors.
31-2231.09. Stock operations and advisory board contracts.	31-2231.21. "Twisting" prohibited.
31-2231.10. Failure to maintain marketing and performance records.	31-2231.22. Powers of the Commissioner; cease and desist orders.
31-2231.11. Unfair discrimination.	31-2231.23. Hearings.
31-2231.12. Rebates: life, health, and annuities.	31-2231.24. Judicial review.
31-2231.13. Unfair discrimination and rebates	31-2231.25. Regulations.

§ 31-2231.01. Definitions.

For the purposes of this chapter, the term:

(1) "Agent" or "Broker" means a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds policies of insurance for persons or risks residing, located, or to be performed in the District of Columbia.

(2) "Annuity contract" means an agreement to make periodic payments in fixed dollar amounts under the terms of a contract for a stated period of time or for the life of the person specified in the contract.

(3) "Commissioner" means the Commissioner of the Department of Insurance and Securities Regulation.

(3A) "Gender identity or expression" shall have the same meaning as provided in § 2-1401.02(12A).

(4) "Insurance business" means the transaction of all matters pertaining to a contract of insurance, both before and after the effectuation of the contract, and all matters arising out of the contract or a claim thereunder.

(5) "Insurance policy" or "insurance contract" means a contract of insurance, indemnity, medical, health, or hospital service; a health maintenance organization plan or coverage; a suretyship; or an annuity that is issued, proposed for issuance, or intended for issuance.

(6) "Insured" means the party named on a policy or contract as the individual with legal rights to the benefits provided by the policy or contract.

(7) "Insurer" means a person, interinsurer, Lloyd's insurer, fraternal benefit society, health maintenance organization, or any other legal entity engaged in the business of insurance, including agents, brokers, and third-party administrators. Insurer shall also mean medical service plans and hospital service plans.

(8) "Person" means any natural or artificial entity, including individuals, partnerships, associations, trusts, or corporations.

(9) “Unfair trade practices” means the commission of any one or more of the acts prohibited by §§ 31-2231.02 through 31-2231.21, or regulations promulgated hereunder, with such frequency to indicate a general business practice to engage in the proscribed conduct.

(Apr. 3, 2001, D.C. Law 13-265, § 101, 48 DCR 1225; June 25, 2008, D.C. Law 17-177, § 16(a), 55 DCR 3696.)

Effect of amendments. — D.C. Law 17-177 added par. (3A).

Legislative history of Law 13-265. — Law 13-265, the “Insurance Trade and Economic Development Amendment Act of 2000”, was introduced in Council and assigned Bill No. 13-806, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on

November 8, 2000, and December 5, 2000, respectively. Signed by the Mayor on January 2, 2001, it was assigned Act No. 13-555 and transmitted to both Houses of Congress for its review. D.C. Law 13-265 became effective on April 3, 2001.

Legislative history of Law 17-177. — For Law 17-177, see notes following § 31-1601.

§ 31-2231.02. General prohibition.

(a) This chapter shall be construed to permit an administrative remedy only, and nothing in this chapter shall be construed to create or imply a private cause of action for a violation of this chapter.

(b) This chapter shall not be construed to extinguish, limit, or otherwise impair any existing right in law or equity for conduct that is otherwise actionable.

(Apr. 3, 2001, D.C. Law 13-265, § 102, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.03. Misrepresentations and false advertising of insurance policies.

No person shall make, issue, circulate, or cause to be made, issued or circulated, an estimate, illustration, circular or statement, sales presentation, omission, or comparison that:

- (1) Misrepresents the benefits, advantages, conditions, or terms of a policy;
- (2) Misrepresents the dividends or share of the surplus to be received on a policy;
- (3) Makes a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- (4) Is misleading or is a misrepresentation as to the financial condition of an insurer or as to the legal reserve system upon which a life insurer operates;
- (5) Uses a name or title of a policy or class of policies misrepresenting the true nature thereof;
- (6) Is a misrepresentation, including an intentional erroneous quotation of a premium rate for the purpose of inducing, or tending to induce, the purchase, lapse, forfeiture, exchange, conversion, or surrender of a policy;

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, a policy;

(8) Misrepresents a policy as being shares of stock; or

(9) Uses a name which deceptively infers or suggests that it is an insurer if it is not an insurer.

(Apr. 3, 2001, D.C. Law 13-265, § 103, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.04. False information and advertising generally.

No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in a notice, circular, pamphlet, letter, or poster, or over a radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with respect to the business of insurance or with respect to an insurer in the conduct of its insurance business which is untrue, deceptive, or misleading.

(Apr. 3, 2001, D.C. Law 13-265, § 104, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.05. Defamation.

No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating or circulating, of an oral or written statement or a pamphlet, circular, article, or literature, which is false with respect to, maliciously critical of, or derogatory to, the financial condition of an insurer and which is calculated to injure the insurer.

(Apr. 3, 2001, D.C. Law 13-265, § 105, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.06. Boycott, coercion, and intimidation.

No person shall enter into an agreement to commit, or by a concerted action commit, an act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

(Apr. 3, 2001, D.C. Law 13-265, § 106, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.07. Illegal dealing in premiums; excess charges for insurance.

(a) Subject to the acceptance of the risk by the insurer, no person shall willfully collect a premium or charge for insurance which is not then provided, or is not in due course to be provided, by an insurance policy issued by an insurer.

(b) No person shall willfully collect as a premium or charge for insurance a sum in excess of the premium or charge specified in the policy and applicable to such insurance in accordance with the classifications and rates as filed with and approved by the Commissioner. In a case where the classifications, premiums, or rates are not required to be filed and approved, the premium or charge shall not be in excess of that specified in the policy and fixed by the insurer. This subsection shall not prohibit a reasonable fee or charge for insurance premium payment plans, regardless of the number of installment payments involved.

(Apr. 3, 2001, D.C. Law 13-265, § 107, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.08. False statements and entries.

(a) No person shall knowingly file with an insurance regulatory or other public official, knowingly make, publish, disseminate, circulate, or deliver to a person, or place before the public, or knowingly cause directly or indirectly to be made, published, disseminated, circulated, delivered to a person, or placed before the public, a false material statement of fact as to the financial condition of an insurer.

(b) No person shall knowingly:

(1) Make a false entry of a material fact in a book, report, or statement of an insurer;

(2) With intent to deceive an agent of the Commissioner lawfully appointed to examine the insurer's condition or any of its affairs, fail to make a true entry of any material fact pertaining to the business of an insurer in a book, report, or statement of the insurer; or

(3) Make a false material statement to an insurance department official.

(Apr. 3, 2001, D.C. Law 13-265, § 108, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.09. Stock operations and advisory board contracts.

No person, as an inducement to purchase insurance, shall issue or deliver, or permit its agents, officers, or employees to issue or deliver:

- (1) Agency company stock or other capital stock, benefit certificates, or shares in a common law corporation;
- (2) Securities; or
- (3) A special or advisory board contract or other contracts of any kind promising returns and profits.

(Apr. 3, 2001, D.C. Law 13-265, § 109, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.10. Failure to maintain marketing and performance records.

No person shall fail to maintain its books, records, documents, and other business records in such order that data regarding complaints, claims, rating, underwriting, and marketing are not accessible and retrievable for examination by the Commissioner. Data for at least the current calendar year and the 2 preceding years shall be maintained.

(Apr. 3, 2001, D.C. Law 13-265, § 110, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.11. Unfair discrimination.

(a) No person shall commit or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a life insurance policy or contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the policy or contract.

(b) No person shall commit or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, fees, or rates charged for a policy or contract of accident or health insurance; in the benefits payable under a policy or contract of accident or health insurance; in any of the terms or conditions of the policy or contract of accident or health insurance; or in any other manner. This section shall not prohibit a fee or charge for insurance premium payment plans, regardless of the number of installments involved.

(b-1) For the purposes of subsections (a) and (b) of this section, no person shall inquire, directly or indirectly, as to whether an insured or applicant is, or has been, the victim of an intrafamily offense, sexual assault, dating violence, or stalking, or make use of information as to an insured or applicant's status as a victim of an intrafamily offense, sexual assault, dating violence, or

stalking; provided, that this subsection shall not prohibit a person from asking about a medical condition or from using medical information to underwrite or to carry out its duties under a policy, even if the medical information is related to a medical condition that the person knows or has reason to know is related to an intrafamily offense, sexual assault, dating violence, or stalking, to the extent otherwise permitted under this chapter or applicable law. For purposes of this subsection, the term “intrafamily offense” shall have the same meaning as provided in § 16-1001(8).

(c) No person shall refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of marital status, race, color, personal appearance, sexual orientation, gender identity or expression, matriculation, political affiliation, or an individual’s status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking. Nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits or prohibit or limit the operation of fraternal benefit societies. For the purposes of this subsection, the term “matriculation” shall have the same meaning as in § 2-1401.02(18).

(d) No person shall terminate or modify coverage, or refuse to issue or refuse to renew, a property and casualty policy or a life, health, or annuity policy, solely because the applicant or insured, or an employee of either, is mentally or physically impaired. A termination, modification, or refusal shall be based on sound actuarial principles or related to actual or reasonably anticipated experience. This subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of an insurance policy or contract.

(e) No person shall refuse to insure an individual solely because another insurer has refused to write a policy or has cancelled or has refused to renew an existing policy in which the individual was named an insured. This subsection shall not prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(Apr. 3, 2001, D.C. Law 13-265, § 111, 48 DCR 1225; Oct. 3, 2001, D.C. Law 14-28, § 2702(a), 48 DCR 6981; June 25, 2008, D.C. Law 17-177, § 16(b), 55 DCR 3696; Apr. 8, 2011, D.C. Law 18-360, § 202(a), 58 DCR 896.)

Effect of amendments. — D.C. Law 14-28 rewrote subsec. (c) which had read as follows: “(c) No person shall refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex, marital status, race, religion, or national origin of the individual. Nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this section shall prohibit or limit the operation of fraternal benefit societies.”

D.C. Law 17-177, in subsec. (c), substituted

“sexual orientation, gender identity or expression” for “sexual orientation”.

D.C. Law 18-360, in subsec. (b), substituted “health insurance” for “health insurance policy”, “policy or contract of accident or health insurance” for “contract or policy”, and “policy or contract of health insurance” for “policy or contract”; added subsec. (b-1); and, in subsec. (c), substituted “political affiliation, or an individual’s status as a victim of an intrafamily offense, sexual assault, dating violence, or stalking” for “or political affiliation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2502(a) of

Fiscal Year 2002 Budget Support Emergency Act of 2001 (D.C. Act 14-124, August 3, 2001, 48 DCR 7861).

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-28. — For Law 14-28, see notes following § 31-2001.

Legislative history of Law 17-177. — For Law 17-177, see notes following § 31-1601.

Legislative history of Law 18-360. — Law 18-360, the “Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010”, was introduced in Council and assigned Bill No. 18-792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and

second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18-710 and transmitted to both Houses of Congress for its review. D.C. Law 18-360 became effective on April 8,

Editor’s notes. — Section 203 of D.C. Law 18-360 provided: “Sec. 203. Application. This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.”

§ 31-2231.12. Rebates: life, health, and annuities.

(a) No person shall knowingly:

(1) Permit, or offer to make, a policy or contract of life insurance, annuity, or accident and health insurance, or agreement as to such policy or contract, other than as plainly expressed in the policy or contract issued thereon; or

(2) Pay, allow, give, or offer to pay, allow, or give, directly or indirectly as inducement to such policy or contract:

(A) A rebate of premiums payable on the policy or contract;

(B) A special favor or advantage in the dividends or other benefits thereon; or

(C) A valuable consideration or inducement not specified in the contract.

(b) No person shall directly or indirectly give, sell, purchase, or offer, or agree to give, sell, purchase, or offer as inducement to the policy or contract specified in subsection (a) of this section, or in connection therewith:

(1) Stocks, bonds, or other securities of an insurance company or other corporation, association, or partnership;

(2) Dividends or profits accrued or to accrue thereon; or

(3) Anything of value not specified in the contract.

(c) No person shall receive or accept as inducement to a policy or contract:

(1) A rebate of premium payable on the policy or contract;

(2) A special favor or advantage in the dividends or other benefits to accrue on the policy or contract; or

(3) A valuable consideration or inducement not specified in the contract.

(d) Section 31-2231.11 or this section shall not be construed to include within the definition of discrimination or rebates any of the following practices:

(1) In the case of a contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided, that the bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(2) In the case of life insurance policies issued on the industrial debit, preauthorized check, bank draft, or similar plans, making allowance to

policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder at the end of the first or a subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year;

(4) Reduction of premium rates for policies of large amounts, but not exceeding savings in issuance and administration expenses reasonably attributable to the policies as compared with policies of similar plans issued in smaller amounts;

(5) Issuing life or health insurance policies or annuity contracts on a salary savings or payroll deduction plan, or other distribution plan, at reduced rates reasonably commensurate with the savings made by the use of the plan; and

(6) Issuance of health insurance policies which provide for increases in benefits to policyholders who maintain their policies continuously in force without lapse for specified periods.

(e) Section 31-2231.11 or this section shall not be construed to include within the definition of securities an inducement to purchase insurance, the selling or offering for sale, contemporaneously with life insurance, mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the United States Securities and Exchange Commission where the shares, the face amount certificates, or the insurance may be purchased independently of, and not contingent upon, purchase of the other, at the same price and upon similar terms and conditions as where purchased independently.

(f) For the purposes of § 31-2231.11 or this section, the term “valuable consideration” shall not include any educational materials, promotional materials, or articles of merchandise that cost less than \$10, regardless of whether a policy or contract is purchased.

(Apr. 3, 2001, D.C. Law 13-265, § 112, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.13. Unfair discrimination and rebates prohibited; property, casualty, and surety insurance.

(a) No person offering property, casualty, or surety insurance, or an employee or representative thereof, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insure, or after insurance has been effected, a rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or a special favor or advantage in the dividends or other benefits to accrue thereon, or a valuable consideration or inducement whatsoever, not specified or provided for in the policy, except to the

extent provided for in an applicable filing with the Commissioner as allowed by law.

(b) An insured named in a policy, or an employee of the insured, shall not knowingly receive, offer, or accept, directly or indirectly, a rebate, discount, abatement, credit, or reduction of premium, or a special favor or advantage or valuable consideration or inducement, as proscribed by subsection (a) of this section.

(c) No insurer shall make or permit an unfair discrimination between insured property having like insuring or risk characteristics, in the premium or rates charged for insurance, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the insurance.

(d) Notwithstanding any other provision in this section, an insurer shall not make or permit a differential in ratings, premium payments, or dividends based on the marital status, race, color, personal appearance, sexual orientation, gender identity or expression, matriculation, or political affiliation of an applicant or policy holder unless there is actuarial justification for the differential. For the purposes of this subsection, the term “matriculation” shall have the same meaning as in § 2-1401.02(18). Nothing in this section shall limit or otherwise restrict any discount, rating, or credit program filed with the Commissioner.

(e) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents or brokers or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, lawful dividends, savings, or unabsorbed premium deposits.

(f) No person shall commit or permit an unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the individual or risk, unless the action is for a sound business purpose that is not a mere pretext for unfair discrimination, or unless the refusal, cancellation, or limitation is required by law or regulatory mandate.

(g) No person shall commit or permit an unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained in a residential property risk, solely because of the age of the residential property.

(h)(1) For purposes of § 31-2231.12 or this section, the term “valuable consideration” shall not include any educational materials, promotional materials, or articles of merchandise that cost less than \$10, regardless of whether a policy or contract is purchased.

(2) For the purposes of this section, the term “insurance” shall include suretyship and the term “policy” shall include a bond.

(3) This section shall not apply to wet marine and transportation insurance.

(Apr. 3, 2001, D.C. Law 13-265, § 113, 48 DCR 1225; Oct. 3, 2001, D.C. Law 14-28, § 2702(b), 48 DCR 6981; June 25, 2008, D.C. Law 17-177, § 16(c), 55 DCR 3696.)

Effect of amendments. — D.C. Law 14-28 rewrote subsec. (d) which had read:

“(d) Notwithstanding any other provision in this section, an insurer shall not make or permit a differential in ratings, premium payments, or dividends based on the sex, physical handicap, or disability of an applicant or policyholder unless there is actuarial justification for the differential.”

D.C. Law 17-177, in subsec. (d), substituted “sexual orientation, gender identity or expression” for “sexual orientation”.

Emergency legislation. — For temporary (90 day) amendment section, see § 2502(b) of Fiscal Year 2002 Budget Support Emergency Act of 2001 (D.C. Act 14-124, August 3, 2001, 48 DCR 7861).

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 17-177. — For Law 17-177, see notes following § 31-1601.

§ 31-2231.14. Interlocking ownerships, management.

(a) An insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer, or have a common management with another insurer, unless the retention, investment, acquisition, or common management is inconsistent with another provision of law, or, by reason thereof, the business of the insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly.

(b) A person otherwise qualified may be a director of 2 or more insurers which are competitors unless the effect is to lessen substantially competition between insurers generally or tends materially to create a monopoly.

(Apr. 3, 2001, D.C. Law 13-265, § 114, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.15. Unfair financial planning practices; an insurance agent or broker.

(a) No person shall hold himself or herself out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters if the person is in fact engaged only in the sale of insurance policies or contracts.

(b)(1) No person shall engage in the business of financial planning without disclosing to the client before the execution of the agreement provided for in subsection (c) of this section or the solicitation of the sale of a product or service that:

(A) He or she is also an insurance salesperson; and

(B) A commission for the sale of an insurance product will be received in addition to a fee for financial planning, if it is the case.

(2) The disclosure under this subsection may be made by including it in a disclosure document required by federal or state securities law.

(c) All fees, other than commissions for financial planning by an insurance producer, shall be based upon a written agreement signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party. The agreement shall specifically state:

(1) The services for which the fee is to be charged;

(2) The amount of the fee to be charged or the manner in which it will be determined; and

(3) The client shall not be required to purchase an insurance product through the person furnishing the agreement.

(d) The person furnishing the agreement shall retain a copy for at least 3 years after completion of services. A copy shall be available to the Commissioner upon request.

(Apr. 3, 2001, D.C. Law 13-265, § 115, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.16. Failure to provide claims history.

(a) A property and casualty insurer shall provide the following loss information for the 3 previous policy years to the first named insured within 30 days of receipt of the first named insured's written request:

(1) On all claims, the date and description of occurrence, and the total amount of payments; and

(2) For any occurrence not included in paragraph (1) of this subsection, the date and description of the occurrence.

(b) If the first named insured is requested by a prospective insurer to provide detailed loss information other than that required under subsection (a) of this section, the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than is reasonably required to underwrite the same line or class of insurance. The insurer shall provide the information under subsection (a) of this section to the first named insured as soon as possible, but not later than 20 days after the receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant, solely because the prospective insurer is unable to obtain loss reserve information.

(c) The Commissioner may promulgate regulations to exclude the provision of the loss information as set forth in subsection (a) of this section for any line or class of insurance if it can be shown that the information is not needed for that line or class of insurance or if the provision of loss information is otherwise required by law.

(d) Information provided under subsection (a) of this section shall not be

subject to discovery by a party other than the insured, the insurer, and the prospective insurer.

(Apr. 3, 2001, D.C. Law 13-265, § 116, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.17. Unfair claim settlement practices.

(a) No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

(1) Knowingly misrepresent pertinent facts or insurance policy provisions relating to the claim at issue;

(2) Refuse to pay a claim for a reason that is arbitrary or capricious based on all available information;

(3) Attempt to settle a claim on the basis of an application which is altered without notice to, or the knowledge or consent of, the insured;

(4) Fail to include with a claim paid to an insured or beneficiary a statement setting forth the coverage under which payment is being made;

(5) Fail to settle a claim promptly whenever liability is reasonably clear under one portion of a policy in order to influence settlements under other portions of the policy; or

(6) Fail promptly upon request to provide a reasonable explanation of the basis for a denial of a claim.

(b) No person shall commit or perform with such frequency as to indicate a general business practice any of the following:

(1) Knowingly misrepresent pertinent facts or insurance policy provisions relating to coverage at issue;

(2) Fail to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;

(3) Fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refuse to pay claims without conducting a reasonable investigation;

(5) Fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed or after having completed its investigation related to the claims;

(6) Not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(7) Compel insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds or beneficiaries;

(8) Attempt to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application or policy;

(9) Attempt to settle claims on the basis of an application which was materially altered without notice to or knowledge or consent of the insured;

(10) Make claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

(11) Make known to insureds or claimants of a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises of less than the amount awarded in arbitration;

(12) Unreasonably delay the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

(13) Fail, in the case of claims denials or offers of compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action; or

(14) Make false or fraudulent statements or representations on, or relative to an application for, a policy, for the purpose of obtaining a fee, commission, money, or other benefit from a provider or individual person.

(c) The Commissioner may impose a penalty of up to \$1,000 for each violation of subsection (a) of this section or of a regulation promulgated under subsection (a) of this section. The Commissioner may impose a penalty for violations of subsection (b) of this section as provided in § 31-4305, § 31-2602.24 [repealed], § 31-2502.03, and § 31-1105.

(Apr. 3, 2001, D.C. Law 13-265, § 117, 48 DCR 1225; Oct. 19, 2002, D.C. Law 14-213, § 20(a), 49 DCR 8140.)

Effect of amendments. — D.C. Law 14-213, in subsec. (c), validated a previously made technical correction.

D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 13-265. — For

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-2231.18. Failure to maintain complaint handling procedures.

An insurer shall maintain a complete record of all complaints which it has received since the date of its last examination as otherwise required in this chapter. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time to process each complaint. For purposes of the section, the term “complaint” shall mean a written communication from a policyholder, subscriber, claimant, or insurance department primarily expressing a grievance.

(Apr. 3, 2001, D.C. Law 13-265, § 118, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.19. Misrepresentation in insurance application.

(a) No person shall make false or fraudulent statements or representations

on, or relative to, an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from a provider or individual person.

(b) No person shall cause to be presented a false or fraudulent claim, or proof in support of a claim, for the payment of the loss upon a contract of insurance or prepare, make, or subscribe a false or fraudulent account, certificate, affidavit, proof of loss, or other document or writing with the intent that it may be presented or used in support of a false or fraudulent claim.

(Apr. 3, 2001, D.C. Law 13-265, § 119, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

CASE NOTES

In general.

Under District of Columbia law, allegations that commercial general liability insurer reasonably relied on one or more of insurance broker's false statements and omissions in insurance application supported negligent misrepresentation claim, even if complaint included neither an express statement that insurer's reliance was objectively reasonable, nor a statement that a reasonable insurer could rely on statements in an insurance application. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 329 F.Supp.2d 45, 2004 U.S. Dist. LEXIS 15045 (2004).

Under District of Columbia law, a claim for negligent misrepresentation requires a showing that: (1) the defendant made a false statement or omission of a fact; (2) the statement was in violation of a duty to exercise reasonable care; (3) the false statement or omission involved a material issue; (4) the plaintiff reasonably and to its detriment relied on the false information; and (5) the defendant's challenged conduct proximately caused injury to the plaintiff. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 329 F.Supp.2d 45, 2004 U.S. Dist. LEXIS 15045 (2004).

§ 31-2231.20. Favored agent or insurer; coercion of debtors.

(a) No person shall require, as a condition to the lending of money or extension of credit, or a renewal thereof, that the person to whom the money or credit is extended, or whose obligation a creditor is to acquire or finance, negotiate an insurance policy or renewal thereof through a particular insurer or group of insurers or agent, broker, or group of agents or brokers.

(b) No person who lends money or extends credit shall:

(1) Solicit insurance for the protection of real property after a person indicates interest in securing a first mortgage credit extension until the person has received a commitment in writing from the lender as to a loan or credit extension;

(2) Unreasonably reject an insurance policy provided by a borrower for the protection of property securing a credit or lien. A rejection shall not be unreasonable if it is based on reasonable standards and uniformly applied relating to the extent of coverage required and the financial soundness and the services of an insurer. The standards shall not discriminate against a particular type of insurer or reject a policy because it contains coverage in addition to that required in the credit transaction;

(3) Require, directly or indirectly, that a debtor, borrower, mortgagor,

purchaser, insurer, broker, or agent pay a separate charge or consideration in connection with the handling of an insurance policy required as security for a loan on real estate or pay a separate charge or consideration of any kind for substituting the insurance policy of one insurer for that of another. This prohibition shall not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the security instrument;

(4) Use or disclose, without the prior written consent of the borrower, mortgagor, or purchaser taken at a time other than the making of the loan or extension of credit, information relative to an insurance policy which is required by the credit transaction for the purpose of replacing the insurance; or

(5) Require a procedure or condition of duly licensed agents, brokers, or insurers not customarily required of agents, brokers, or insurers affiliated, or in any way connected, with the person who lends money or extends credit.

(c) A person who lends money or extends credit and who solicits insurance on real and personal property shall explain to the borrower in writing that the insurance related to the credit extension may be purchased from an insurer or agent of the borrower's choice, subject only to the lender's right to reject a given insurer or agent as provided in subsection (b)(2) of this section. Compliance with disclosures as to insurance required by truth-in-lending laws or comparable state laws shall constitute compliance with this subsection.

(d) The Commissioner may examine and investigate those insurance-related activities of a person or insurer that the Commissioner believes may be in violation of this section. A affected person may submit to the Commissioner a complaint or material pertinent to the enforcement of this section.

(e) Nothing herein shall prevent a person who lends money or extends credit from placing insurance on real or personal property if the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(f) Nothing contained in this section shall apply to credit life or credit accident and health insurance.

(Apr. 3, 2001, D.C. Law 13-265, § 120, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.21. "Twisting" prohibited.

No person shall make or issue, or cause to be made or issued, a written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in a policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, retain, exchange, or convert an insurance policy.

(Apr. 3, 2001, D.C. Law 13-265, § 121, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.22. Powers of the Commissioner; cease and desist orders.

(a) The Commissioner may examine and investigate the affairs of a person engaged in the business of insurance in the District of Columbia to determine whether the person has been or is engaged in an unfair trade practice, an unfair method of competition, or an unfair or deceptive action practice under this chapter. The Commissioner may suspend or revoke the license or certificate of authority for a person that violates this chapter or a rule or regulation adopted under this chapter, or fails to comply with an order of the Commissioner.

(b)(1) The Commissioner may enforce this chapter, or any rules and regulations adopted under this chapter, by issuing an order:

(A) To cease and desist from the violation and further similar violations; and

(B) Requiring the violator to correct the violation, including the restitution of money or property to a person aggrieved by the violation.

(2) If a violator fails to comply with an order issued under paragraph (1) of this subsection, the Commissioner may impose a civil penalty of up to \$1,000 for each violation from which the violator failed to cease and desist or which the violator failed to correct.

(c) The Commissioner may request the Corporation Counsel of the District of Columbia ("Corporation Counsel") take appropriate action in the Superior Court of the District of Columbia ("Superior Court") for the enforcement of an order issued under this section. The Corporation Counsel may also seek, and the Superior Court may order or decree, damages and other relief allowed by law, including restitution. In an action brought by the Corporation Counsel under this section, the Corporation Counsel may be awarded attorney's fees and costs.

(d) In determining the amount of financial penalty to be imposed under subsection (b) of this section, the Commissioner shall consider the following:

(1) The seriousness of the violation;

(2) The good faith of the violator;

(3) The violator's history of previous violations;

(4) The deleterious effect of the violation on the public and the insurance industry;

(5) The assets of the violator; and

(6) Any other factor relevant to the determination of the financial penalty.

(Apr. 3, 2001, D.C. Law 13-265, § 122, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.23. Hearings.

(a) Before the Commissioner takes an action under § 31-2231.22, the Commissioner shall provide the person alleged to have violated this chapter an opportunity for a hearing.

(b) Notice of the hearing shall be given, and the hearing shall be held, in accordance with §§ 2-509 and 2-510.

(c) The hearing notice shall be served at the person's principal place of business by certified mail, return receipt requested, at least 30 days before the hearing.

(d) The Commissioner may administer oaths or affirmations, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents deemed relevant to the matter at issue.

(e) In the case of a refusal of a person to comply with any subpoena issued or to testify with respect to any matter upon which the person may be lawfully interrogated, the Superior Court, on application of the Commissioner, may issue an order requiring the person to comply with the subpoena or to testify.

(Apr. 3, 2001, D.C. Law 13-265, § 123, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-2231.24. Judicial review.

If, after any hearing under § 31-2231.23, the Commissioner does not find a violation of this chapter, an aggrieved person may, within 60 days after the decision has been issued, or later in connection with § 31-2231.11(a), (b), or (b-1) upon a showing of good cause by a victim of an intrafamily offense, sexual assault, dating violence, or stalking, appeal the decision of the Commissioner to the District of Columbia Court of Appeals. In addition, any person subject to an order of the Commissioner under § 31-2231.22 may obtain a review of the order by filing in the District of Columbia Court of Appeals, within 60 days after the order has been issued, a written petition requesting that the order of the Commissioner be set aside. Except as provided above for the time for filing an appeal, appeals shall be made in accordance with § 2-510.

(Apr. 3, 2001, D.C. Law 13-265, § 124, 48 DCR 1225; Apr. 8, 2011, D.C. Law 18-360, § 202(b), 58 DCR 896.)

Effect of amendments. — D.C. Law 18-360 substituted “issued, or later in connection with § 31-2231.11(a), (b), or (b-1) upon a showing of good cause by a victim of an intrafamily offense, sexual assault, dating violence, or stalking, appeal” for “issued, appeal”.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

Editor's notes. — Section 203 of D.C. Law 18-360 provided: “Sec. 203. Application. This title shall apply to policies and certificates of insurance that are health benefit plans as defined under section 2(4) of the Health Insurance Coverage for Habilitative Services for Children

Act of 2006, effective March 2, 2007 (D.C. Law 16-198; D.C. Official Code § 31-3271(4)), that are issued 90 days after the effective date of this title. This title shall not apply to short-term limited duration health benefit plans.”

§ 31-2231.25. Regulations.

The Commissioner may, in accordance with § 2-505, promulgate reasonable rules, regulations, or orders as are necessary or appropriate to carry out and effectuate the provisions of this chapter.

(Apr. 3, 2001, D.C. Law 13-265, § 125, 48 DCR 1225.)

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

CHAPTER 23. UNITED STATES BRANCH DOMESTICATION OF NON-U.S. INSURERS.

Sec.

31-2301. Definitions.

31-2302. Domestication permitted.

31-2303. Prior written approval of domestication agreement.

31-2304. Authorization and execution of domestication agreement.

Sec.

31-2305. Final approval by Commissioner.

31-2306. Consummation of domestication agreement; transfer of deposits; withdrawal of trusted assets.

31-2307. Regulations.

§ 31-2301. Definitions.

For purposes of this chapter, the term:

(1) "Domestication" means the reorganization under this chapter of the United States branch of a Non-U.S. insurer whereby a domestic or foreign insurer acquires all the business and assets and assumes all the liabilities of the branch.

(2) "Domestic insurer" means a stock insurance company incorporated under the laws of the District of Columbia.

(3) "Foreign insurer" means a stock insurance company incorporated under the laws of any other state of the United States.

(4) "Non-U.S. insurer" means a stock insurance company organized under the laws of a foreign country.

(5) "United States branch" means the business unit through which business is transacted within the United States by a Non-U.S. insurer and the assets and liabilities of the insurer within the United States pertaining to such business.

(Oct. 21, 2000, D.C. Law 13-194, § 2, 47 DCR 7427.)

Legislative history of Law 13-194. — D.C. Law 13-194, the "United States Branch Domestication Act of 2000," was introduced in Council and assigned Bill No. 13-723, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on

first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-422 and transmitted to both Houses of Congress for its review. D.C. Law 13-194 became effective on October 21, 2000.

§ 31-2302. Domestication permitted.

(a)(1) Upon compliance with this chapter, a Non-U.S. insurer which is authorized to use the District of Columbia ("District") as a state of entry to transact insurance business through its United States branch and which owns beneficially, directly or indirectly, all outstanding shares of a domestic insurer or of a foreign insurer qualified and licensed in the District to write all the kinds of insurance for which the United States branch is qualified and licensed, may domesticate its United States branch by entering into a written domestication agreement with such domestic or foreign insurer providing for the acquisition of the business and assets, and the assumption of all liabilities, of the United States branch, by the domestic or foreign insurer for no consideration, except for (A) such assumption of liabilities, and (B) additional consideration payable by the issuance of shares of the acquiring insurer.

(2) The domestication shall be subject to prior written approval by the Commissioner if the acquiring insurer is a domestic insurer or by the chief insurance regulatory official of the state of organization if it is a foreign insurer.

(3) The domestication shall be subject to final approval by the Commissioner if the acquiring insurer is a domestic insurer or by the chief insurance regulatory official of the state of organization if it is a foreign insurer.

(b) Any shares of the acquiring insurer, or voting trust certificates therefor, held among the trustee assets of the United States branch or held in a trust created by the Non-U.S. insurer of which the Non-U.S. insurer is a beneficiary shall be deemed to be shares held beneficially, but indirectly, by the Non-U.S. insurer.

(c) The acquiring insurer may be licensed to engage in the insurance business in the District either before entering into the domestication agreement or, if the Commissioner approves, effective with consummation of the domestication agreement in accordance with § 31-2306.

(d) This chapter shall not be construed to (1) authorize an insurance company to do any kind of insurance business not authorized by its charter, or (2) authorize a foreign or Non-U.S. insurer to do any kind of insurance business in the District not authorized by its license or certificate of authority to do business in the District.

(Oct. 21, 2000, D.C. Law 13-194, § 3, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 31-2301.

§ 31-2303. Prior written approval of domestication agreement.

An acquisition of assets and assumption of liabilities under § 31-2302(a) shall be initiated by filing with the Commissioner, for prior written approval as required by § 31-2302(a)(2), a copy of the domestication agreement, executed by the Non-U.S. insurer and the acquiring insurer, in a form satisfactory to (1) the Commissioner if the acquiring insurer is a domestic insurer, or (2) both the Commissioner and the chief insurance regulatory official of the state of organization if the acquiring insurer is a foreign insurer. If he is satisfied that the domestication agreement complies with this chapter and that the interests of policyholders and creditors of the United States branch are not materially adversely affected, the Commissioner may approve the domestication agreement, subject to a subsequent review and final approval as required under § 31-2302(a)(3) and 6 [§ 31-2305].

(Oct. 21, 2000, D.C. Law 13-194, § 4, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 31-2301.

§ 31-2304. Authorization and execution of domestication agreement.

(a) A domestication agreement shall be authorized, adopted, approved, executed, and acknowledged by the Non-U.S. insurer under the laws of the country where it is organized.

(b) A domestication agreement shall also be approved, adopted, and authorized by the acquiring insurer's board of directors, executed by its president or any vice president, and attested by its secretary or assistant secretary under its corporate seal, or, in the case of a foreign insurer, as otherwise provided in the laws of the state of its organization.

(Oct. 21, 2000, D.C. Law 13-194, § 5, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 35-5201.

§ 31-2305. Final approval by Commissioner.

(a) The following shall be submitted to the Commissioner for final approval of the domestication agreement as required under § 31-2302(a)(3):

(1) An executed counterpart of the domestication agreement;

(2) Certified copies of the corporate proceedings of the acquiring insurer and the Non-U.S. insurer approving, adopting, and authorizing the execution of the domestication agreement;

(3) A certification by an officer of the United States branch that the domestication agreement satisfies the requirements of this chapter; and

(4) In the case of a foreign insurer, the written approval of the chief insurance regulatory official of the state in which the foreign insurer is organized.

(b) If he is satisfied that the domestication agreement complies with this chapter, that all the required documents have been submitted, and that the interests of policyholders and creditors of the United States branch are not materially adversely affected, the Commissioner may approve, as required under § 31-2302(a)(3), the domestication agreement.

(Oct. 21, 2000, D.C. Law 13-194, § 6, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 31-2301.

§ 31-2306. Consummation of domestication agreement; transfer of deposits; withdrawal of trusteed assets.

(a)(1) The domestication of the United States branch shall be effective upon the final approval of the Commissioner of the domestication agreement under § 31-2305 ("consummation").

(2)(A) All assets of the United States branch, including all its rights and property, shall be deemed transferred to, and vested in, the acquiring insurer

and the acquiring insurer shall be deemed to have assumed all liabilities of the United States branch.

(B) All deposits of the United States branch held by commissioners, state officers, or other state regulatory agencies under state laws, shall be deemed held as security for the full performance by the acquiring insurer of its assumption as direct liabilities of all of the liabilities to policyholders and creditors within the United States of the United States branch, and the deposits shall be deemed admitted assets of the acquiring insurer and reported as such in its annual financial statements and other reports required to be filed by it in the District.

(3) Upon the ultimate release by a state officer or agency of deposits described in paragraph (2)(B) of this subsection, the securities and cash released shall be delivered and paid over to the acquiring insurer as the lawful successor in interest to the United States branch.

(b) Contemporaneously with the consummation of the domestication, notwithstanding §§ 31-2203 and 31-2204, the Commissioner shall:

(1) Transfer to the acquiring insurer's account the securities deposited by the United States branch in compliance with this chapter; and

(2) Consent to the withdrawal from the trust by the trustee of the trustee assets deposited by the United States branch in compliance with this chapter and the transfer and delivery to the acquiring insurer of all assets held by the trustee; provided, that if a United States branch is domesticated into a foreign insurer, the Commissioner, unless otherwise satisfied that the interests of policyholders of in force business and of creditors on outstanding claims are protected, may defer consent to the withdrawal of so much of the trustee assets as in the Commissioner's judgment is reasonably required to protect such interests as of the date of domestication, and shall consent to their withdrawal from time to time as such interests expire.

(Oct. 21, 2000, D.C. Law 13-194, § 7, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 31-2301.

§ 31-2307. Regulations.

The Commissioner may, in accordance with § 2-505, promulgate rules, regulations, and orders as are necessary or appropriate to carry out the provisions of this chapter. The Council may approve or disapprove any rules, regulations, or orders promulgated by the Commissioner within 30 days after the date transmitted to the Council. If no action is taken by the Council, the rules, regulations, or orders shall be deemed to be approved.

(Oct. 21, 2000, D.C. Law 13-194, § 8, 47 DCR 7427.)

Legislative history of Law 13-194. — For Law 13-194, see notes following § 31-2301.

SUBTITLE III. FIRE, CASUALTY, MARINE, MOTOR VEHICLE AND RELATED INSURANCE.

CHAPTER 24. COMPULSORY/NO-FAULT MOTOR VEHICLE INSURANCE.

Sec.

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31-2402. Definitions.

31-2403. Required insurance.

31-2404. Personal injury protection.

31-2405. Lawsuit restriction and opportunity
for arbitration under optional in-
surance.31-2406. Availability of required and optional
insurance and benefits.

Sec.

31-2407. Priorities for the payment of personal
injury protection benefits.

31-2408. [Repealed].

31-2408.01. Uninsured Motorist Fund.

31-2409. Consumer protection.

31-2410. Special provisions.

31-2411. Miscellaneous provisions.

31-2412. [Expired.]

31-2413. Penalties; adjudications.

§ 31-2401. Findings; purpose.

(a) *Findings.* — The Council of the District of Columbia finds that:

(1) Motorists, motor vehicle passengers, and pedestrians in the District are not adequately protected, by current law and practice, from the consequences of motor vehicle accidents.

(2) If a person suffers personal injuries because of an accident involving a motor vehicle in the District, he or she is unlikely to recover the amount of his or her actual losses because:

(A) Approximately 50% of the victims do not satisfy the prerequisites to compensation under the present law;

(B) Approximately 40% of the operators in the District do not maintain any motor vehicle insurance or have other financial resources sufficient to pay losses;

(C) The average motor vehicle insurance policy in the District will pay only up to \$10,000 for the personal injuries of any 1 victim, a sum that is insufficient to compensate adequately a victim with serious injuries; and

(D) Satisfaction of the prerequisites to compensation under the present law is time-consuming and expensive to policyholders because a victim must establish that the accident was the fault of another person; that the person injured was free from contributory fault; and that the injuries suffered were the natural and probable consequences of the accident.

(3) Far greater protection to victims of motor vehicle accidents is available at a lower price than that afforded for coverage currently available.

(4) The purchase of this better insurance protection should be compulsory because of the great potential of a motor vehicle to cause personal injury.

(b) *Purpose.* — It is the purpose of this chapter to provide adequate protection for victims who are injured in the District or who are injured while riding in motor vehicles registered or operated in the District.

(Sept. 18, 1982, D.C. Law 4-155, § 2, 29 DCR 3491.)

Prior Codifications. — 1981 Ed., § 35-2101.

Legislative history of Law 4-155. — Law

4-155, the "Compulsory/No-Fault Motor Vehicle Insurance Act of 1982," was introduced in Council and assigned Bill No. 4-140, which was

referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first, amended first, second amended first, and second readings on May 11, 1982, May 25, 1982, June 8, 1982, and June 22, 1982, respectively. Deemed approved without Mayoral signature upon expiration of the Mayoral review

period on July 22, 1982, it was assigned Act No. 4-226 and transmitted to both Houses of Congress for its review.

Delegation of Authority. — Delegation of authority pursuant to Law 6-96, see Mayor's Order 86-186, October 17, 1986.

CASE NOTES

ANALYSIS

Construction and application.

Contracts.

Jurisdiction.

Parties.

Standing.

Validity.

Construction and application.

Amendments to no-fault statute under challenge did not render moot appeal from portion of district court order striking down challenged provision where the preamendment statute still governed actions arising out of accidents occurring prior to the effective date of the amendment. D.C. Code 1981, § 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Exclusivity clause of Workers' Compensation Act did not bar employee from seeking benefits from employer under No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-304. *Holmes v. Washington Metro. Area Transit Authority*, 731 F. Supp. 1115, 1990 U.S. Dist. LEXIS 889 (1990).

Although benefits payable under workers' compensation are primary over personal injury protection benefits payable under the District of Columbia No-Fault Motor Vehicle Insurance Act, remedies under workers' compensation allowing an employer to recoup benefits paid from liable third parties are not primary over the remedies set forth in the No-Fault Act; in situations where both no-fault and workers' compensation apply, an employer may recoup benefits paid under workers' compensation only through avenues provided by the No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Although interpretation of District of Columbia no-fault law by Office of Insurance Superintendent of the District was not binding on district court on issue whether taxicab driver was entitled to avoid limitations on civil liability set forth in law, it was entitled to considerable deference. D.C. Code 1981, § 35-2101 et seq. *Nasaka v. Data Access Systems*, 602 F. Supp. 761, 1985 U.S. Dist. LEXIS 22565 (1985).

Amendments to No-Fault Act which became effective in 1986 did not apply to accident which occurred on April 4, 1986. D.C. Code 1981,

§§ 35-2101 to 35-2114. *Walker v. District of Columbia*, 656 A.2d 722, 1995 D.C. App. LEXIS 58 (1995).

For purposes of recovery under this act it is sufficient if the uninsured vehicle can be shown to be the cause of the accident. *Maddox v. Doe*, 122 WLR 69 (Super. Ct. 1993).

Nothing in this chapter or in its legislative history demonstrates a legislative intent to compensate a victim without a preliminary finding that the accident, itself, caused the injury in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

Contracts.

Rental car company could not shift responsibility for primary insurance coverage on rental car that was involved in collision to renter's personal insurance provider; such a contractual arrangement would be against public policy embodied in Compulsory/No-Fault Motor Vehicle Insurance Act and would alter terms of renter's contract with his insurer to provide only excess coverage for rental cars, without insurer's consent. *Sharp v. Ward*, 132 WLR 1997 (Super. Ct. 2004).

An insurance carrier could draft a contract which provided for a reduction of the policy limit by any amount received in compensation for the injuries inflicted by an uninsured motorist, including worker's compensation. *Millender v. Nationwide Ins. Co.*, 119 WLR 1953 (Super. Ct. 1991).

Where an insurer provides for a reduction of the policy limit by any amount received as compensation for injuries, if such a contract fails to provide the mandatory minimum amount of coverage required of the insurer by the No-Fault Act because of such a reduction, the contract must yield to the statute, and the court may not enforce the contract to the extent that it violates the governing law. *Millender v. Nationwide Ins. Co.*, 119 WLR 1953 (Super. Ct. 1991).

Jurisdiction.

Pendent jurisdiction could be exercised over challenge to District of Columbia no-fault law based on alleged violation of the District of Columbia Self-Government Act where plaintiff also presented a substantial equal protection claim. D.C. Code 1981, § 1-233(a)(4, 8); 18 U.S.C. § 1331. *Dimond v. District of Columbia*,

792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Parties.

Insurer which sought to intervene in action challenging provisions of District of Columbia no-fault law only two days after district court clarified its ruling to indicate the effect of its holding acted timely. Fed.Rules Civ.Proc.Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Because District of Columbia had no financial stake in outcome of challenge to provisions of no-fault law, it was inadequate representative of insurer which had based its premiums on the provisions of the law and the insurer was thus entitled to intervene as of right in action challenging constitutionality of the law. Fed.R.Civ.Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Standing.

Plaintiffs did not have standing to challenge the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2101 et seq.] on grounds that District of Columbia city council failed to comply with procedural requirements of the Self-Government Act requiring a bill to be read twice before passage [D.C. Code 1981, § 1-229(a)] as plaintiffs asserted nothing more than a generalized grievance alleging abstract injury in nonobservance of the Act. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Insured who purchased motor vehicle insurance as required by the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2101 et seq.], who alleged that he sustained physical injuries in a

motor vehicle accident, and who alleged that his medical expenses would likely not exceed \$5,000 had standing to challenge provision of the Act barring suits against tort-feasors for noneconomic loss unless the victim's medical expenses exceed \$5,000. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

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Validity.

It is a legitimate exercise of a state's police power to require no-fault insurance as a condition to the operation of a motor vehicle. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

It is within the power of the District of Columbia to prescribe conditions for registration of motor vehicles, including the purchase of out-of-state liability coverage, and to require insurance companies doing business in the District to provide certain coverages. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

§ 31-2402. Definitions.

As used in this chapter:

(1) The term "accident" means an untoward and unforeseen occurrence arising out of the maintenance or use of:

(A) A motor vehicle;

(B) A vehicle operated or designed for operation upon a highway by power other than muscular power with respect only to any pedestrian or any occupant of that vehicle other than the owner or operator of that vehicle; or

(C) Any other vehicle covered by the insurance coverages required by § 31-2406.

(2) Repealed.

(3) The term "beneficiary" means a person who is named in a policy of

personal injury protection insurance as a person who is entitled to the benefits of personal injury protection insurance.

(4) The term "Department" means the Department of Motor Vehicles established pursuant to § 50-901.

(5) The term "Director" means the Director of the Department or the Director's designee.

(6) The term "District" means the District of Columbia.

(7) The term "highway" means the entire width between the boundary lines of every publicly maintained way, when any part thereof is open to the use of the public for purposes of vehicular or pedestrian travel.

(8) The term "individual" means a natural person.

(9) The term "injury" means bodily harm to an individual that is sustained in an accident, and any illness, disease, or death resulting from that bodily harm.

(9A) "Insurance Identification Card" means a document issued by an insurer as proof of insurance for a motor vehicle that lists the name of the insurer, the policy number, the name of the insured, the period of coverage for the insurance, and the make, model, and vehicle identification number.

(10) The term "insured" means a named insured or any other person insured in an insurance policy, with the exception of those persons specifically excluded by endorsement on the insurance policy.

(11) The term "insurer" means any person, company, or professional association licensed in the District of Columbia that provides motor vehicle liability protection or any self-insurer.

(12) The term "license" means a license or permit to operate a motor vehicle issued under the laws of the District.

The term "license" includes a driver's license; a temporary or learner's permit; the privilege of any person to drive a motor vehicle whether or not such person holds a valid license issued by the District government; the privilege conferred upon a nonresident by the laws of the District pertaining to the operation by a nonresident of a motor vehicle; or any other license issued under authority delegated to the Director.

(13) The term "loss" means economic detriment incurred as a result of an accident resulting in injury, consisting of and limited to medical and rehabilitation expenses, work loss inclusive of replacement services loss, and death benefits. The term "loss" does not include noneconomic loss.

(14) The term "maintenance or use" with respect to a motor vehicle means any activity involving or related to the operation of or transportation by a motor vehicle, including occupying, entering into, alighting from, repairing, or servicing.

The term "maintenance or use" does not include conduct within the course of a business of repairing, servicing, or otherwise maintaining motor vehicles unless the conduct is off the business premises or unless it is conduct in the course of loading or unloading a motor vehicle.

(15) The term "Mayor" means the Mayor of the District of Columbia or the Mayor's designee.

(16) The term "motorcycle" means any motor vehicle having either a tandem arrangement of 2 wheels or a tricyclic arrangement of 3 wheels and

having a seat or saddle for the use of the operator. The term “motorcycle” does not include a tractor.

(17) The term “motor vehicle” means any device propelled by an internal-combustion engine, electricity, or steam, including any non-operational vehicle that is being restored or repaired. The term “motor vehicle” does not include traction engines used exclusively for drawing vehicles in fields, road rollers, vehicles propelled only upon rails and tracks, personal mobility devices, as defined by § 50-2201.02(12), or a battery-operated wheelchair when operated by a person with a disability.

(18) The term “named insured” means the person identified in the declaration of the insurance policy.

(19) The term “noneconomic loss” means pain, suffering, inconvenience, physical or mental impairment, and other nonpecuniary damage recoverable under the tort law applicable to injury arising out of the maintenance or use of a motor vehicle.

(20) The term “operator” means a person who drives or is in actual physical control of a motor vehicle or who is exercising control over or steering a motor vehicle being pushed or towed by a motor vehicle.

(21) The term “owner” means any person, corporation, firm, agency, association, organization, or federal, state, or local government agency or other authority or other entity having the property or title to a vehicle or bicycle used or operated in the District; any registrant of a vehicle used or operated in the District; or any person, corporation, firm, agency, association, organization, or federal, state, or local government agency or authority or other entity in the business of renting or leasing vehicles or bicycles to be used or operated in the District.

(22) The term “passenger vehicle” means any vehicle other than one registered as a commercial vehicle or for livery, rental, sightseeing, or taxi purposes.

(23) The term “person” means any natural person, firm, copartnership, association, government, government agency, or instrumentality.

(24) The term “personal injury protection” means the benefits provided pursuant to § 31-2404.

(25) The term “registration certificate” means a certificate or its duplicate issued by the Director to a registrant, containing any or all of the information that appeared on his or her application for registration, the number of the owner’s identification tags issued to the registrant for use on the vehicle described on the card and other information as the Director may determine, or a registration certificate or its duplicate, issued by the Director to a new car dealer, or used car dealer, containing any or all of the information that appeared on his or her application for dealer’s identification tags, the number of the dealer’s identification tags issued to the new car dealer or used car dealer for use as provided by 18 DCMR and any other information the Director may require.

(26) The term “self-insurer” means any person having received a certificate of self-insurance issued by the Mayor pursuant to § 50-1301.79.

(27) The term “stacking” means a legal procedure wherein the limits of liability applicable to a single motor vehicle liability policy of insurance are

added to the limits of liability of all motor vehicles which may be insured by 1 motor vehicle liability policy of insurance involved in 1 accident.

(28) The term "state" means any state, territory, or possession of the United States or any possession or territory of Canada. The term "state" includes the District of Columbia.

(29) The term "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking or the Commissioner's designee.

(30) The term "survivor" means an individual identified in the wrongful death statute of the District, as one entitled to receive benefits by reason of the death of a victim.

(31) The term "taxicab" means any public vehicle for hire having a seating capacity of less than 8 passengers, exclusive of the driver, except ambulances, funeral cars, vehicles used exclusively for sightseeing purposes, or vehicles for which the rate is fixed solely by the hour.

(32) The term "trailer" means a vehicle with or without motor power intended to be used for carrying property or persons and drawn or intended to be drawn by a motor vehicle, whether such vehicle without motor power carries the weight of the property or persons wholly on its own structure or whether a part of such weight rests upon or is carried by a motor vehicle.

(32A) The term "underinsured motor vehicle" means an insured motor vehicle where the limits on 3rd-party personal liability or property damage coverage under the insurance required by § 31-2406 are insufficient to pay the loss up to the limit of uninsured motor vehicle coverage as requested by the insured.

(33) The term "vehicle" means a motor vehicle; a trailer; or an appliance moved over a highway on wheels or traction tread including draft animals and beasts of burden.

(34) The terms "victim" and "motor vehicle accident victim" mean an individual who sustains injury as a result of an accident.

(Sept. 18, 1982, D.C. Law 4-155, § 3, 29 DCR 3491; Mar. 15, 1985, D.C. Law 5-176, § 2, 32 DCR 748; Mar. 4, 1986, D.C. Law 6-96, § 2(a), 32 DCR 7245; May 21, 1997, D.C. Law 11-268, § 10(v), 44 DCR 1730; Mar. 26, 1999, D.C. Law 12-184, § 2, 45 DCR 7796; Apr. 27, 2001, D.C. Law 13-289, § 101(a), 48 DCR 2057; Mar. 25, 2003, D.C. Law 14-235, § 2, 49 DCR 9788; Mar. 13, 2004, D.C. Law 15-105, § 90(a), 51 DCR 881; June 11, 2004, D.C. Law 15-166, § 4(n), 51 DCR 2817; June 8, 2006, D.C. Law 16-117, § 201(a), 53 DCR 2548; Mar. 6, 2007, D.C. Law 16-224, § 201, 53 DCR 10225.)

Prior Codifications. — 1981 Ed., § 35-2102.

Effect of amendments. — D.C. Law 13-289 repealed par. (2) and rewrote par. (4). Pars. (2) and (4) had read:

"(2) The term 'Administration Fund' means the fund established by § 31-2408."

"(4) The term 'Department' means the District of Columbia Department of Transportation, established by Reorganization Plan No. 2 of 1975."

D.C. Law 14-235 rewrote par. (17) that had

read as follows: "(17) The term 'motor vehicle' means any device propelled by an internal-combustion engine, electricity, or steam, including any non-operational vehicle that is being restored or repaired. The term 'motor vehicle' does not include traction engines used exclusively for drawing vehicles in fields, road rollers, vehicles propelled only upon rails and tracks, and battery-operated wheelchairs when operated by a handicapped person at speeds not exceeding 10 miles per hour."

D.C. Law 15-105, in par. (17), validated a previously made technical correction.

D.C. Law 15-166, in par. (29), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities, established by Reorganization Order No. 43, dated June 23, 1953,"

D.C. Law 16-117 added par. (9A).

D.C. Law 16-224, in par. (17), revived the provisions of D.C. Law 14-235 that expired on October 1, 2005, and substituted "personal mobility devices, as defined by § 50-2201.02(12), or a battery-operated wheelchair when operated by a person with a disability" for "electric personal assistive mobility devices, as defined by § 50-2201.02(12), and battery-operated wheelchairs when operated by a handicapped person at speeds not exceeding 10 miles per hour".

D.C. Law 16-305, in par. (17), purported to substitute "person with a disability" for "handicapped person".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Motor Vehicle Definition Electric Personal Assistive Mobility Device Exemption Temporary Amendment Act of 2006 (D.C. Law 16-85, April 4, 2006, law notification 53 DCR 3344).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(n) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) amendment of section, see § 2 of Motor Vehicle Definition Electric Personal Assistive Mobility Device Exemption Emergency Amendment Act of 2005 (D.C. Act 16-237, December 22, 2005, 53 DCR 249).

For temporary (90 day) amendment of section, see § 2 of Motor Vehicle Definition Electric Personal Assistive Mobility Device Exemption Congressional Review Emergency Amendment Act of 2006 (D.C. Act 16-323, March 23, 2006, 53 DCR 2567).

For temporary (90 day) amendment of section, see § 201 of Personal Mobility Device Emergency Amendment Act of 2006 (D.C. Act 16-528, December 4, 2006, 53 DCR 9826).

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 5-176. — Law 5-176, the "Motor Vehicle Definition Wheelchair Exception Amendment Act of 1984," was introduced in Council and assigned Bill No. 5-382, which was referred to the Committee on Transportation and Environmental Affairs. The Bill was adopted on first and second readings on December 4, 1984, and December 18, 1984, respectively. Signed by the Mayor on January

11, 1985, it was assigned Act No. 5-241 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21,

Expiration of Law 14-235. — Section 14 of D.C. Law 14-235 provided that the act shall expire on October 1, 2005.

Transfer of Functions. — The functions of the Department of Transportation were transferred to the Department of Public Works by Reorganization Plan No. 4 of 1983, effective March 1, 1984.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance

Administration in the Department of Consumer and Regulatory Affairs was abolished.

CASE NOTES

ANALYSIS

Collateral sources.

Eligibility.

Injuries.

Insured.

Insurer.

Losses.

Motorcycles.

Owners.

Presumptions and burden of proof.

Collateral sources.

Sum, designated as being solely for pain and suffering, received by injured passenger in settlement by suit against uninsured motorist who caused her injuries, was a "collateral source" that reduced the amount of entitlement available to passenger from Uninsured Motorist Fund. D.C. Code 1981, § 35-2114. *Daniel v. District of Columbia Ins. Admin.*, 639 A.2d 590, 1994 D.C. App. LEXIS 45 (1994).

Eligibility.

"Eligibility" as used in No-Fault Act, means fit or capable of procuring insurance for payment of personal injury protection benefits. D.C. Code 1981, § 35-2106(d). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Nothing in this chapter or in its legislative history demonstrates a legislative intent to compensate a victim without a preliminary finding that the accident, itself, caused the injury in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

Injuries.

Under District of Columbia law, as predicted by the district court, injuries sustained by driver as result of explosion of bombs placed in vehicle did not arise from assailant's ownership, maintenance, or use of uninsured motor vehicle, and thus driver could not recover uninsured motorist (UM) benefits under automobile insurance policy, even though assailant had entered vehicle to plant bombs; assailant had completed his activities in vehicle before driver was injured, and bombs, not vehicle, were instrumentalities of injuries. *Sigmund v. Progressive Northern Ins. Co.*, 374 F.Supp.2d 33, 2005 U.S. Dist. LEXIS 11549 (2005).

Injured bus passenger failed to make prima facie showing that she suffered substantial permanent impairment or was virtually incapacitated for 180 continuous days after accident and thus failed to demonstrate that her cause of action against transit authority re-

mained viable under exceptions to Compulsory/No-Fault Motor Vehicle Insurance Act's restrictions against tort actions for noneconomic losses; fact that her back injury was relieved by aspirin indicated that injury was not "serious" within meaning of Act, and without sworn medical affidavits as to extent of her impairment for 180 days, her merely conclusory answers were inadequate to meet requisite "substantially all" exception to Act. D.C. Code 1981, § 35-2105(b). *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Insured.

Passenger who was not covered by automobile policy was not "insured" within meaning of uninsured motorist compensation fund statute, and her health insurance did not disqualify her from receiving compensation under statute; health insurance was relevant, however, as it constituted potential collateral source for her medical expenses and might require reduction in ultimate recovery. D.C. Code 1981, §§ 35-2102(10, 11), 35-2114(c, e). *Tesfamariam v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 645 A.2d 1105, 1994 D.C. App. LEXIS 130 (1994).

Insurer.

A health maintenance organization (HMO) is not an "insurer" within the meaning of a no-fault statute precluding the recovery of personal injury protection (PIP) benefits if the victim is eligible for compensation from another insurer; the no-fault act defines "insurer" as any self-insurer or any person, company, or professional association licensed to provide motor vehicle liability protection. *Carter v. State Farm Mut. Auto. Ins. Co.*, 808 A.2d 466, 2002 D.C. App. LEXIS 545 (2002).

Losses.

Noneconomic losses could be recovered by bringing tort action against driver "at fault" in automobile accident, but Compulsory/No-Fault Motor Vehicle Insurance Act restricted victim's ability to bring such actions; it is threshold question of law for court to decide whether party has met strict statutory requirements as set forth in No-Fault Act to overcome Act's restrictions against tort actions for noneconomic losses. D.C. Code 1981, §§ 35-2101 to 35-2113. *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Economic losses are payable, pursuant to Compulsory/No-Fault Motor Vehicle Insurance

Act, as personal injury protection (PIP) benefits irrespective of whether tort was committed by insured against injured victim; however, victim must prove that insured was "at fault" in order to recover noneconomic losses after she first demonstrates that she meets exception to No-Fault Act's restrictions against tort claims. D.C. Code 1981, §§ 35-2104, 35-2105(b). *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Motorcycles.

Notwithstanding contradictory provisions of District of Columbia's No-Fault Insurance Act, motorcycles were subject to provisions of Act at time of insured's motorcycle accident. D.C. Code 1981, §§ 35-2102, 35-2102(16, 17). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Although motorcycles, including mopeds, are not included in definition of "motor vehicle" in the No-Fault Act, motorcycle or moped was a "motor vehicle" under automobile insurance policy, when so defined therein, for purposes of exclusion from uninsured motorist coverage for insured or relatives living in her household while occupying a motor vehicle owned by insured or such relatives which was not insured under the policy. D.C. Code 1981, §§ 35-2101 et seq., 35-2102 (16, 17) (1984). *Townsend v. Waldo*, 640 A.2d 185, 1994 D.C. App. LEXIS 51 (1994).

Owners.

Under District of Columbia law, as predicted by the district court, assailant who planted bombs in vehicle was not "operator" of vehicle, and thus driver who was injured when bombs exploded could not recover uninsured motorist (UM) benefits under automobile insurance policy, which required that insured be legally en-

titled to recover damages from the owner or operator of an uninsured motor vehicle, even though assailant used vehicle to place bombs in it, where assailant did not drive or control the vehicle in way that could possibly make him driver. *Sigmund v. Progressive Northern Ins. Co.*, 374 F.Supp.2d 33, 2005 U.S. Dist. LEXIS 11549 (2005).

Wife was not "owner" of husband's taxi for purposes of uninsured motorist compensation fund statute; owner of vehicle is person who can sell it, and wife had no right to transfer husband's vehicle. D.C. Code 1981, §§ 35-2214(c), 35-2102(21). *Tesfamariam v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 645 A.2d 1105, 1994 D.C. App. LEXIS 130 (1994).

Meaning of term owner under marriage dissolution equitable distribution of property statute was not applicable to uninsured motorist fund statute. D.C. Code 1981, §§ 16-910, 35-2102(21). *Tesfamariam v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 645 A.2d 1105, 1994 D.C. App. LEXIS 130 (1994).

Rental car company, as "owner" of vehicle under Compulsory/No-Fault Motor Vehicle Insurance Act, had primary duty to provide and maintain appropriate insurance on vehicle before allowing it to be operated by renter, who was involved in collision. *Sharp v. Ward*, 132 WLR 1997 (Super. Ct. 2004).

Presumptions and burden of proof.

This section and § 40-408, although different sections of the Code, are subject to similar legal analysis; just as insurance policies in the District are construed in favor of coverage, the statutory law on agency creates a presumption of consent. *Martinage v. Shapiro, et al.*, 125 WLR 2001 (Super. Ct. 1997).

§ 31-2403. Required insurance.

(a) *Residents of District.* — Each owner of a motor vehicle which is required to be registered or for which a reciprocity sticker is required in the District shall maintain insurance required by § 31-2406. This insurance shall be in effect continuously during the motor vehicle's period of registration or reciprocity.

(b) *Nonresidents of District owning or operating motor vehicles in District.* —

(1) A person who is not a resident of the District who owns a motor vehicle shall not operate the motor vehicle, or permit the motor vehicle to be operated in the District, unless insurance required by § 31-2406 is provided and maintained during the time that the motor vehicle is present in the District.

(2) The Director shall require adequate proof of insurance as required by this section for nonresident owners or operators prior to the return of motor vehicles immobilized by the Department to the nonresident owners or operators.

(c) *Form.* —

(1) Any policy of motor vehicle insurance which is represented or sold as providing, pursuant to this chapter or pursuant to the coverage required by Chapter 13 of Title 50, security covering a motor vehicle or required insurance shall be deemed to provide insurance for payment of the benefits required by this chapter.

(2) The insurance required by this section may be provided under a valid policy of insurance issued by an insurer authorized to transact business in the District or by any other method approved by the Commissioner.

(d) *Administration of requirement.* —

(1)(A) Every person applying to register a motor vehicle in the District or applying for a reciprocity sticker for a motor vehicle in the District shall certify to the Director, on a form supplied by the Director, that the insurance required by this chapter is in effect with respect to that motor vehicle.

(B) The Director may request an insurer to verify any information provided pursuant to subparagraph (A) of this paragraph. The insurer shall accurately respond to the Director's request within 10 business days.

(C) The Director may request that the person who has certified to the Director pursuant to subparagraph (A) of this paragraph submit proof, within 15 business days, that the required insurance is in effect.

(2)(A) The Director shall suspend the reciprocity sticker or vehicle registration certificate issued to the owner of a motor vehicle if the required insurance is not in effect with respect to the motor vehicle. The suspension shall take effect 30 days after service by regular mail of a notice of proposed suspension, unless the person provides proof that he or she has an effective motor vehicle insurance policy and has paid all applicable fines. The person shall also be advised that the fine established pursuant to § 31-2413(b)(2) shall be imposed unless, within the 30 day period, the person proves that the required insurance was maintained during the registration or reciprocity period. The suspension shall remain in effect until the person appears at the Department with proof of an effective motor vehicle insurance policy and pays a reinstatement fee and the applicable fine.

(i)-(iii) Repealed.

(iv) If a person's registration certificate has been suspended as provided for in this subsection, the registration certificate shall not be transferred and the motor vehicle with respect to which the registration certificate was issued shall not be registered in any other name until the Director is satisfied that the transfer of the registration certificate is in good faith and not for the purpose or with the effect of defeating the purposes of this chapter.

(v) Nothing in this section shall affect the rights of any conditional vendor, chattel mortgagee or lessor of the motor vehicle.

(vi) The Director shall suspend or revoke the registration certificate of any motor vehicle transferred in violation of the provisions of this section.

(vii) Decisions of the Director shall be subject to review by the Mayor. Orders and decisions of the board of review shall be appealable pursuant to § 2-510. For the purposes of this sub-subparagraph, the phrase "review by the

Mayor" shall mean a review by any board of review established by the Mayor pursuant to this chapter to review the order or act of any agent of the Mayor.

(B) A motor vehicle with respect to which the registration certificate or reciprocity sticker is suspended under this paragraph may be immobilized by the Department or the Metropolitan Police Department until the insurance required by this section is in effect.

(C) The registration certificate or reciprocity sticker and the tags of any motor vehicle, the registration or reciprocity of which is suspended under this paragraph, shall be recovered whenever possible.

(3)(A) The Director shall require all insurers authorized to sell motor vehicle insurance in the District to furnish to the Department notice of motor vehicle insurance cancellations within 30 days after the effective date of cancellation. Upon receipt of a notice of cancellation concerning a motor vehicle insurance policy on a vehicle registered in the District, the Director shall notify the person in whose name the vehicle is registered that the Director will revoke or cancel the registration of the vehicle pursuant to law.

(B) The insurers shall provide information and cooperate in prosecutions under § 31-2413.

(C) The insurers shall cooperate with, assist, and advise the Director with respect to the detection of persons who have applied for or obtained registration certificate or reciprocity stickers for motor vehicles in the District without first obtaining the insurance, or who cancel or otherwise terminate insurance subsequent to the issuance of a registration certificate or reciprocity stickers.

(4)(A) Repealed.

(B) Payments from the Administration Fund shall be made for the benefit of the Commissioner and for the benefit of the Department but no payments shall be made for costs incurred by either the Department or the Commissioner prior to September 18, 1982, or which would probably have been incurred if this chapter had not been enacted.

(Sept. 18, 1982, D.C. Law 4-155, § 4, 29 DCR 3491; Mar. 14, 1985, D.C. Law 5-159, § 13(a), 32 DCR 30; Mar. 4, 1986, D.C. Law 6-96, § 2(b), 32 DCR 7245; May 21, 1997, D.C. Law 11-268, § 10(v), 44 DCR 1730; Apr. 27, 2001, D.C. Law 13-289, § 101(b), 48 DCR 2057.)

Cross references. — Violations, penalties, and adjudications under this chapter, see § 31-2413.

Prior Codifications. — 1981 Ed., § 35-2103.

Effect of amendments. — D.C. Law 13-289, in subsec. (d), par. (2)(A), rewrote the introductory paragraph, repealed sub-subpars. (i) through (iii), and deleted "or revoked" following "has been suspended" in sub-subpar. (iv); and repealed subsec. (d), par. (4)(A). Subsec. (d), par. (2)(A), introductory paragraph and sub-subpars (i) through (iii), and subsec. (d), par. (4)(A) had read:

"(2)(A) The Director shall suspend or revoke the license, reciprocity sticker, or registration

certificate issued to the owner or operator of a motor vehicle who has been convicted of a violation of this chapter, or who knowingly operates or knowingly permits the operation of an uninsured motor vehicle, or who falsely certifies to the Director that a motor vehicle is an insured motor vehicle, or who knowingly provides the Director with false or inaccurate information as requested by the Director pursuant to this chapter.

"(i) Whenever a license, reciprocity sticker, or registration certificate has been revoked or suspended under the provisions of this subsection the reasons therefor shall be set forth in the order of revocation or suspension. The order shall take effect 5 days after service or notice on

the person whose license, reciprocity sticker, or registration certificate is revoked or suspended unless the person shall have filed with the Director, within the 5-day period, written application for a hearing; provided, that application to the Director for a hearing shall not operate as a stay of the order of the Director when the order has been issued revoking or suspending a reciprocity sticker or registration certificate. The hearing by the Director shall only cover the issues of whether a policy motor vehicle of insurance has been issued to the person and had been in effect on the day the order of revocation or suspension was issued and whether the person provided the Director with false or inaccurate information.

"(ii) If, following the hearing provided for in this subsection, the Director shall sustain the order of revocation or suspension, the order shall become effective immediately.

"(iii) Where the registration certificate, license, or reciprocity sticker has been revoked, no new registration certificate, license, or reciprocity sticker shall be issued to the person for 6 months after the effective date of the order of revocation; provided, that no new registration certificate or reciprocity sticker shall be issued to the person until the motor vehicle is an insured motor vehicle."

"(4)(A) The reasonable costs incurred by the District government in administering and enforcing the requirements of this section and § 31-2413 shall be paid from the Administration Fund."

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 5-159. — Law 5-159, the "End of Session Technical Amendments Act of 1984," was introduced in Council and assigned Bill No. 5-540, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 20, 1984, and December 4, 1984, respectively. Signed by the Mayor on December 10, 1984, it was assigned Act No. 5-224 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

For legislative history of D.C. Law 11- (Act 11-524), see Historical and Statutory Notes following § 31-2402.

Legislative history of Law 13-289. — For D.C. Law 13-289, see notes following § 31-2402.

Transfer of Functions. — See Historical and Statutory Notes following § 35-2102.

Editor's notes. — Subsection (d)(2)(A)(i) is set forth exactly as enacted by D.C. Law 4-155. The reference in the last sentence of that subsection to "policy motor vehicle of insurance" should probably be "motor vehicle policy of insurance", given the context.

CASE NOTES

ANALYSIS

Construction and application.

Coverage.

Jurisdiction.

Nonresidents.

Out-of-state coverage.

Parties.

Rates.

Remedies.

Self-insurers.

Standing.

Suspension of licenses.

Taxis.

Construction and application.

Amendments to no-fault statute under challenge did not render moot appeal from portion of district court order striking down challenged provision where the preamendment statute still governed actions arising out of accidents occurring prior to the effective date of the amendment. D.C. Code 1981, § 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Failure of insured to pay on premiums for uninsured motorist protection for coverage of

his motorcycle did not preclude insured from recovering uninsured motorist benefits, where at time of motorcycle accident, District of Columbia law required insurer to include coverage in every policy and precluded insured from rejecting that coverage. D.C. Code 1981, §§ 35-2103(a), 35-2106(f)(2). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Notwithstanding contradictory provisions of District of Columbia's No-Fault Insurance Act, motorcycles were subject to provisions of Act at time of insured's motorcycle accident. D.C. Code 1981, §§ 35-2102, 35-2102(16, 17). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Provisions of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2103(a)] requiring residents to obtain out-of-state coverage does not violate the Self-Government Act [D.C. Code 1981, § 1-233(a)(3)] which prohibits the enactment of any act not restricted in its application exclusively in or to the District. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part

and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Coverage.

Under District of Columbia law, insured is permitted to purchase uninsured motorist (UM) protection which protects person when he is injured by uninsured motorist by providing him with insurance protection irrespective of fault, and thus, if insured is injured by uninsured motorist and has opted for UM coverage, insured recovers policy amount from his own insurance company. *Athridge v. Aetna Cas. & Sur. Co.*, 163 F.Supp.2d 38, 2001 U.S. Dist. LEXIS 21490 (2001), affirmed in part and reversed in part by, remanded by 351 F.3d 1166, 359 U.S. App. D.C. 22, 2003 U.S. App. LEXIS 24727 (2003).

Failure of insured to pay on premiums for uninsured motorist protection for coverage of his motorcycle did not preclude insured from recovering uninsured motorist benefits, where at time of motorcycle accident, District of Columbia law required insurer to include coverage in every policy and precluded insured from rejecting that coverage. D.C. Code 1981, §§ 35-2103(a), 35-2106(f)(2). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Automobile insurance policy stating that, with respect to third-party liability, insurer would pay damages up to \$300,000 for which an insured is legally liable, while also stating in household exclusion clause that no coverage existed for any bodily injury to any insured or any member of an insured's family residing in the insured's household, was clear and unambiguous and, consequently, not subject to the doctrine of reasonable expectations. *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 1996 D.C. App. LEXIS 129 (1996).

Household exclusion clause, which stated that there was no coverage for injury to insured or insured's family members, and which was contained in automobile policy of husband who was killed while his wife was driving vehicle, was invalid to the extent it conflicted with the District of Columbia's Compulsory No-Fault Motor Vehicle Insurance Act, which requires third-party personal liability coverage for the minimum amounts of \$25,000 per person and \$50,000 per accident; however, there was no bar to enforcement of household exclusion with respect to amounts greater than minimum statutory requirements. D.C. Code 1981, §§ 35-2106(c), 35-2109(l). *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 1996 D.C. App. LEXIS 129 (1996).

Motorcyclist whose motorcycle was not covered by insurance was entitled to recover statutory personal injury protection benefits from insurer for the automobile which was involved

in accident with his motorcycle. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 did not require motorcyclist to be insured as precondition to recovery by motorcyclist of statutory personal injury protection benefits prior to Act's amendment in 1986 which thereafter included motorcycles in definition of motor vehicles under Act. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Jurisdiction.

Pendent jurisdiction could be exercised over challenge to District of Columbia no-fault law based on alleged violation of the District of Columbia Self-Government Act where plaintiff also presented a substantial equal protection claim. D.C. Code 1981, § 1-233(a)(4, 8); 18 U.S.C. § 1331. *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Nonresidents.

Maryland law, not District of Columbia law, governed issue of whether physical contact requirement in uninsured motorist coverage was permissible, even though accident occurred in District of Columbia, where insureds were residents of Maryland, automobile was title and registered in Maryland, original policy and all renewals were addressed and mailed to insureds in Maryland, and all premiums were paid and mailed from Maryland. *Lee v. Wheeler*, 810 F.2d 303, 1987 U.S. App. LEXIS 1990 (C.A.D.C. 1987).

Provision of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2103(b)(1)] requiring nonresidents to obtain insurance coverage which meets the requirements of the Act if they drive their vehicles within the District does not violate the contract clause [U.S. Const. Art. 1, § 10, cl. 1] by placing a burden on the right to contract for the type of insurance coverage preferred by the insurance in conformance with the law of the state wherein the insured resides. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Compelling state interest test was inapplicable to Commerce Clause [U.S. Const. Art. 1, § 8, cl. 3] challenge to provision of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2103(b)(1)] requiring that nonresidents of the District whose vehicles are operated in the District maintain insurance meeting the re-

quirements of the Act. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Provision of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2103(b)(1)] requiring District nonresidents whose motor vehicles are operated in the District to maintain insurance which meets the requirements of the Act does not create an impermissible burden on interstate commerce by imposing higher insurance premiums for additional insurance coverage for driving in the District, as the District's interest in providing adequate protection for motor vehicle accident victims who are injured in the District is outweighed by whatever incidental effect the provision may have on interstate commerce. U.S. Const. Art. 1, § 8, cl. 3. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

District of Columbia Compulsory No-Fault Motor Vehicle Insurance Act does not require foreign insurer to offer optional personal injury protection insurance to nonresident who is statutorily required to purchase other specified coverage as condition of operating motor vehicle in District of Columbia. D.C. Code 1981, §§ 35-2101 et seq., 35-2103(b). *Dove v. Dairyland Ins. Co.*, 562 A.2d 1199, 1989 D.C. App. LEXIS 153 (1989).

Motorcyclist who did not carry insurance on motorcycle was not entitled to recover personal injury protection benefits from insurer of his own automobile, as motorcyclist, who was a nonresident, was not operating his automobile in District at time of accident. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Uninsured, nonresident pedestrian injured in foreign state was not entitled to recover personal injury protection benefits under District of Columbia No-Fault Act, even though he was struck by District of Columbia motorist. D.C. Code 1981, § 35-2106(d) (repealed). *Taylor v. Canady*, 536 A.2d 93, 1988 D.C. App. LEXIS 7 (1988).

Automobile policy purchased by District of Columbia motorist, which failed to provide coverage for nonresident, uninsured pedestrian injured in foreign state, did not violate District of Columbia No-Fault Act. D.C. Code 1981, § 35-2106(d) (repealed). *Taylor v. Canady*, 536 A.2d 93, 1988 D.C. App. LEXIS 7 (1988).

Out-of-state coverage.

Provisions of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, §§ 35-2103(a), 35-2106(c)] re-

quiring resident motorist obtain out-of-state coverage and requiring insurers doing business in the District to provide out-of-state coverage do not deprive insureds of substantive due process by eliminating a freedom to choose the insurance protection best suited to the insured's needs. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Provisions of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, §§ 35-2103(a), 35-2106(c)] which require residents to obtain out-of-state coverage and which require insurance companies doing business in the District to include out-of-state liability coverage do not burden interstate commerce in violation of the Commerce Clause [U.S. Const. Art. 1, § 8, cl. 3]. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Parties.

Where, as events transpired, would be intervenor's participation at the appellate level as an amicus had been sufficient to protect its interest, decision that it should have been permitted to intervene as of right would result in it being permitted to intervene for the limited purpose of participating in the future proceedings. *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Because District of Columbia had no financial stake in outcome of challenge to provisions of no-fault law, it was inadequate representative of insurer which had based its premiums on the provisions of the law and the insurer was thus entitled to intervene as of right in action challenging constitutionality of the law. Fed.R.Civ.Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Rates.

Insurer which could not recoup, through an increase in premiums, additional costs which would result from invalidation of personal injury threshold for lawsuits under the District of Columbia no-fault law had inadequate interest in challenge to the law to intervene as of right. Fed.R.Civ.Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Remedies.

Although benefits payable under workers' compensation are primary over personal injury

protection benefits payable under the District of Columbia No-Fault Motor Vehicle Insurance Act, remedies under workers' compensation allowing an employer to recoup benefits paid from liable third parties are not primary over the remedies set forth in the No-Fault Act; in situations where both no-fault and workers' compensation apply, an employer may recoup benefits paid under workers' compensation only through avenues provided by the No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Workers' compensation benefits paid by an employer which satisfy in whole or in part the personal injury protection benefits which self-insured employer must pay under the District of Columbia No-Fault Motor Vehicle Insurance Act are effectively PIP payments; thus, employer who has paid workers' compensation benefits that partially or fully satisfy the required PIP benefits may obtain reimbursement from the insurer of a liable third party. D.C. Code 1981, § 35-2111(d). *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Bus driver who brought negligence suit against driver of vehicle which struck bus was not required to reimburse his employer from any recovery for payments employer made to driver under workers' compensation for medical bills and lost wages, considering that driver could recover only for noneconomic loss under the District of Columbia No-Fault Motor Vehicle Insurance Act, and statute limited employee's rights to driver's rights. D.C. Code 1981, §§ 35-2105, 36-335. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Under the District of Columbia No-Fault Motor Vehicle Insurance Act, self-insured employer of injured bus driver had a right of reimbursement from liable third parties for workers' compensation payments which were effectively personal injury protection payments to driver, regardless of source, subject to a determination of fault. D.C. Code 1981, § 35-2111. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Self-insurers.

District of Columbia's Compulsory/No-Fault Motor Vehicle Insurance Act did not require qualified self-insurer, transit authority, to provide uninsured motorist protection. D.C. Code 1981, §§ 35-2104, 35-2106(a)(1)(D), (c-1, f). *Coates v. Washington Metro. Area Transit Authority*, 742 F. Supp. 10, 1990 U.S. Dist. LEXIS 8794 (1990).

Standing.

Nonresidents of the District of Columbia did not have standing to challenge requirement of the District's no-fault law [D.C. Code 1981,

§ 35-2103(b)(1)] requiring them to obtain insurance meeting the requirements of the law if they drive their motor vehicles in the District on grounds that it interfered with their First Amendment [U.S. Const. Amend. 1] right to enter the District of Columbia to petition the government. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Residents of Maryland and Virginia had standing to challenge constitutionality of provision of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2103(b)(1)] which requires nonresidents of the District of Columbia whose motor vehicles are driven in the District to maintain coverage that meets the requirements of the Act. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Suspension of licenses.

Provision for extending period of suspension of driver's license beyond 90 days for operating vehicle without insurance if the motorist is given a limited occupational license may only be applied after the owner or operator applies for an occupational license and such a license is in fact issued; it was error to impose period of suspension of six months simply on the basis that the operator needed a license for employment where the operator did not request an occupational license. D.C. Code 1981, § 35-2103(d)(2)(A). *Carpenter v. District of Columbia Traffic Adjudication Appeal Bd.*, 530 A.2d 680, 1987 D.C. App. LEXIS 420 (1987).

Taxicabs.

"Exemption" of taxicabs from District of Columbia no-fault law applies only to mandatory insurance provision; exemption does not prevent a taxicab owner or driver from claiming benefits under the law, nor does it entitle him to avoid law's limitations on civil liability. D.C. Code 1981, §§ 35-2103, 35-2105. *Nasaka v. Data Access Systems*, 602 F. Supp. 761, 1985 U.S. Dist. LEXIS 22565 (1985).

Section of automobile policy barring uninsured motorist coverage for any vehicle used to carry persons for fee precluded uninsured motorist coverage for insured while he was driving his taxicab, despite his claim that coverage denial violated applicable statutory provisions and despite his reliance on out-of-state case law holding that uninsured motorist coverage was personal and traveled with insured. D.C. Code 1981, § 35-2106(a)(1)(D). *Hill v. Maryland Casualty Co.*, 620 A.2d 1336, 1993 D.C. App. LEXIS 43 (1993).

Statutory exemption of taxicabs from provisions of No-Fault Act distinguishes between taxicabs and taxicab drivers and, as such, refers only to mandatory insurance requirement for taxicabs, not to limitation on civil liability for taxicab drivers, and does not exempt drivers from limitation which No-Fault Act imposes on his or her common-law right to sue. D.C. Code 1981, §§ 35-2103(a), (d)(1)(A), 35-2111(e); § 35-2105(a) (1985). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

Statutory exemption of taxicabs from provisions of No-Fault Act distinguishes between taxicabs and taxicab drivers and, as such, refers only to mandatory insurance requirement for taxicabs, not to limitation on civil liability for taxicab drivers, and does not exempt drivers from limitation which No-Fault Act imposes on his or her common-law right to sue. D.C. Code 1981, §§ 35-2103(a), (d)(1)(A), 35-2111(e); § 35-2105(a) (1985). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

§ 31-2404. Personal injury protection.

(a) *In general.* —

(1) In addition to insurance required to be provided by an insurer under § 31-2406, each insurer shall offer to each person required to have insurance under this chapter optional personal injury protection insurance as set forth in this section. Personal injury protection shall provide coverage for victims for injuries arising from accidents resulting from the operation or use of a motor vehicle by the insured or use of the insured motor vehicle within or outside the District. It shall provide benefits for medical and rehabilitation expenses, work loss, and funeral benefits as set forth in this section. Personal injury protection benefits are applicable only to a victim who is an insured or an occupant of the insured's vehicle or of a vehicle which the insured is driving.

(2) An insured may obtain, solely at his or her option, any 1 or any combination of the 3 coverages for the benefits set forth in this section.

(3) A self-insurer shall state on the application for self insurance whether the self-insurer is providing personal injury protection benefits as part of the motor vehicle insurance provided for the vehicles owned by the self-insurer.

(b) *Payment without regard to fault.* — The benefits set forth in this section with respect to personal injury protection shall be provided without regard to, and irrespective of, negligence, freedom from negligence, fault, or freedom from fault on the part of any person.

(c) *Medical and rehabilitation expenses.* —

(1) Personal injury protection benefits shall be paid for each victim for that victim's medical and rehabilitation expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for the victim's care, recovery, or rehabilitation.

(2) Except when the victim requires special or intensive care, the medical and rehabilitation expenses paid by personal injury protection insurance shall not include charges for a hospital room which are in excess of a reasonable and necessary charge for semiprivate accommodations.

(3) Nothing in this section shall prohibit payment as medical and rehabilitation expenses of any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

(4) No payment shall be made under this subsection unless the provider of the product, service, or accommodation involved is licensed or approved and complies with any applicable laws or regulations pertinent thereto.

(5) The maximum benefits payable pursuant to this subsection for any victim shall not be less than \$50,000. Insurers providing personal injury

protection coverage shall provide insurance package optionals with medical and rehabilitation coverage of \$50,000 and \$100,000 for each victim.

(d) *Work loss.* —

(1) Personal injury protection benefits shall be paid pursuant to this subsection to each victim for that victim's work loss occurring during his or her life consisting of:

(A) Loss of income for work which a victim would have performed after the date of the accident if he or she had not been injured in the accident (not including any expected reduction in the amount payable by that victim for purposes of federal and District income taxation, which amount shall be presumed to be 20% of the amount otherwise payable unless the victim can show a different income taxation effect); and

(B) Replacement services loss for expenses which a victim reasonably incurred in obtaining ordinary and necessary services in lieu of those that the victim would have performed for personal or family benefit (but not for income) during the first 3 years after the date of the accident if he or she had not been injured in the accident.

(2) The maximum benefits payable for work loss for the victim for any 1 accident shall not be less than \$12,000. Insurers shall provide insurance options with work loss coverages of at least \$12,000 and \$24,000.

(3) Benefits payable for work loss do not include any loss incurred after the date of a victim's death, if the victim dies for any reason.

(e) *Funeral benefits.* — Personal injury protection benefits shall be paid to the survivors of each victim as funeral and funeral-related benefits. The benefits payable pursuant to this subsection for funeral and funeral-related benefits for any 1 victim shall be actual costs up to \$4,000.

(Sept. 18, 1982, D.C. Law 4-155, § 5, 29 DCR 3491; Mar. 4, 1986, D.C. Law 6-96, § 2(c), 32 DCR 7245.)

Section references. — This section is referred to in §§ 31-2402, 31-2405, 31-2406, and 31-2413.

Prior Codifications. — 1981 Ed., § 35-2104.

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see His-

torical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

CASE NOTES

ANALYSIS

Construction and application.
Coverage.
Health insurance.
Household exclusion.
Noneconomic losses.
Nonresidents.
Parties.
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Construction and application.

Maryland law, not District of Columbia law, governed issue of whether physical contact re-

quirement in uninsured motorist coverage was permissible, even though accident occurred in District of Columbia, where insureds were residents of Maryland, automobile was title and registered in Maryland, original policy and all renewals were addressed and mailed to insureds in Maryland, and all premiums were paid and mailed from Maryland. *Lee v. Wheeler*, 810 F.2d 303, 1987 U.S. App. LEXIS 1990 (C.A.D.C. 1987).

In situations in which the District of Columbia No-Fault Motor Vehicle Insurance Act and the District of Columbia Workers' Compensa-

tion Act apply, benefits payable under workers' compensation are primary over benefits payable under no-fault; thus, personal injury protection benefits must be paid by a self-insured employer only if benefits paid under workers' compensation do not accord an injured individual the full measure of recovery he would receive from PIP benefits. D.C. Code 1981, §§ 35-2101 to 35-2113, 35-2110(b, f), 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Coverage.

Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 did not require motorcyclist to be insured as precondition to recovery by motorcyclist of statutory personal injury protection benefits prior to Act's amendment in 1986 which thereafter included motorcycles in definition of motor vehicles under Act. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist who did not carry insurance on motorcycle was not entitled to recover personal injury protection benefits from insurer of his own automobile, as motorcyclist, who was a nonresident, was not operating his automobile in District at time of accident. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist whose motorcycle was not covered by insurance was entitled to recover statutory personal injury protection benefits from insurer for the automobile which was involved in accident with his motorcycle. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Plaintiff's uninsured motorist policy covered injuries incurred when a dog jumped from a parked truck and attacked the plaintiff. *Martinage v. Shapiro, et al.*, 125 WLR 2001 (Super. Ct. 1997).

Nothing in this chapter or in its legislative history demonstrates a legislative intent to compensate a victim without a preliminary finding that the accident, itself, caused the injury in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

Health insurance.

At time of insured's motorcycle accident, insured was permitted double recovery for his medical expenses under his personal injury protection coverage and health insurance provided by his employer; statute at time of accident precluded double recovery specifically for social security, workers' compensation, temporary nonoccupational disability insurance, and any government program, but separate health insurance. D.C. Code 1981, §§ 35-2106(g), 35-

2110(b). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Insureds, who had primary medical coverage, had an affirmative obligation under their secondary personal injury protections (PIP) coverage to fulfill all the actual and constructive conditions precedent to that insurance policy, including exhausting their medical insurance resources before calling upon PIP insurer to pay any medical bills arising from motor vehicle accident. *Turner v. State Farm Insurance Company*, 134 WLR 867 (, (Super. Ct. 2005)).

Household exclusion.

Automobile insurance policy stating that, with respect to third-party liability, insurer would pay damages up to \$300,000 for which an insured is legally liable, while also stating in household exclusion clause that no coverage existed for any bodily injury to any insured or any member of an insured's family residing in the insured's household, was clear and unambiguous and, consequently, not subject to the doctrine of reasonable expectations. *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 1996 D.C. App. LEXIS 129 (1996).

Household exclusion clause, which stated that there was no coverage for injury to insured or insured's family members, and which was contained in automobile policy of husband who was killed while his wife was driving vehicle, was invalid to the extent it conflicted with the District of Columbia's Compulsory No-Fault Motor Vehicle Insurance Act, which requires third-party personal liability coverage for the minimum amounts of \$25,000 per person and \$50,000 per accident; however, there was no bar to enforcement of household exclusion with respect to amounts greater than minimum statutory requirements. D.C. Code 1981, §§ 35-2106(c), 35-2109(l). *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 1996 D.C. App. LEXIS 129 (1996).

Noneconomic losses.

District of Columbia No-Fault Motor Vehicle Insurance Act barred injured bus driver's recovery for medical bills and lost wages from driver of vehicle which struck bus; under clear language of the statute, bus driver could maintain a civil action only for noneconomic loss. D.C. Code 1981, § 35-2105. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Economic losses are payable, pursuant to Compulsory/No-Fault Motor Vehicle Insurance Act, as personal injury protection (PIP) benefits irrespective of whether tort was committed by insured against injured victim; however, victim must prove that insured was "at fault" in order to recover noneconomic losses after she first demonstrates that she meets exception to No-Fault Act's restrictions against tort claims. D.C.

Code 1981, §§ 35-2104, 35-2105(b). *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Motorist who failed to maintain insurance as required by No-Fault Act could not recover for noneconomic losses which were below threshold level of Act. D.C. Code 1981, § 35-2105(b)(6). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Nonresidents.

District of Columbia Compulsory No-Fault Motor Vehicle Insurance Act does not require foreign insurer to offer optional personal injury protection insurance to nonresident who is statutorily required to purchase other specified coverage as condition of operating motor vehicle in District of Columbia. D.C. Code 1981, §§ 35-2101 et seq., 35-2103(b). *Dove v. Dairyland Ins. Co.*, 562 A.2d 1199, 1989 D.C. App. LEXIS 153 (1989).

Parties.

District of Columbia resident who failed to maintain insurance paying personal injury protection benefits, as required by Compulsory/No-Fault Motor Vehicle Act, could not maintain negligence action against resident insured motorist to recover for injuries and damages suffered in automobile accident in District of Columbia, including losses which would have been recoverable under insurance policy for payment of personal injury protection benefits. D.C. Code 1981, § 35-2106(d). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Taxicab driver who rented vehicle from cab company, though failing to maintain insurance for vehicle, was not an owner of vehicle required to provide and maintain personal injury protection benefits and, hence, was not ineligible for insurance under No-Fault Act and was therefore barred from maintaining a civil action based on liability against any person with respect to injury as to which personal injury protection benefits were payable. D.C. Code 1981, § 35-2105(a, b) (1985); § 35-2106(d, e) (repealed). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

Workers compensation.

Although benefits payable under workers' compensation are primary over personal injury protection benefits payable under the District of Columbia No-Fault Motor Vehicle Insurance

Act, remedies under workers' compensation allowing an employer to recoup benefits paid from liable third parties are not primary over the remedies set forth in the No-Fault Act; in situations where both no-fault and workers' compensation apply, an employer may recoup benefits paid under workers' compensation only through avenues provided by the No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Workers' compensation benefits paid by an employer which satisfy in whole or in part the personal injury protection benefits which self-insured employer must pay under the District of Columbia No-Fault Motor Vehicle Insurance Act are effectively PIP payments; thus, employer who has paid workers' compensation benefits that partially or fully satisfy the required PIP benefits may obtain reimbursement from the insurer of a liable third party. D.C. Code 1981, § 35-2111(d). *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Bus driver who brought negligence suit against driver of vehicle which struck bus was not required to reimburse his employer from any recovery for payments employer made to driver under workers' compensation for medical bills and lost wages, considering that driver could recover only for noneconomic loss under the District of Columbia No-Fault Motor Vehicle Insurance Act, and statute limited employee's rights to driver's rights. D.C. Code 1981, §§ 35-2105, 36-335. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Under the District of Columbia No-Fault Motor Vehicle Insurance Act, self-insured employer of injured bus driver had a right of reimbursement from liable third parties for workers' compensation payments which were effectively personal injury protection payments to driver, regardless of source, subject to a determination of fault. D.C. Code 1981, § 35-2111. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Comprehensive Merit Personnel Act entitled District of Columbia, as employer, to reimbursement for workers' compensation payments made to employees from tort recoveries for those same injuries, regardless of nature of damages recovered by employees from third parties. D.C. Code 1981, § 1-624.32. *Lee v. District of Columbia*, 559 A.2d 308, 1989 D.C. App. LEXIS 104 (1989).

§ 31-2405. Lawsuit restriction and opportunity for arbitration under optional insurance.

(a) A victim shall notify the personal injury protection insurer within 60

days of an accident of the victim's election to receive personal injury protection benefits.

(b) A victim who elects to receive personal injury protection benefits may maintain a civil action based on liability of another person only if:

(1) The injury directly results in substantial permanent scarring or disfigurement, substantial and medically demonstrable permanent impairment which has significantly affected the ability of the victim to perform his or her professional activities or usual and customary daily activities, or a medically demonstrable impairment that prevents the victim from performing all or substantially all of the material acts and duties that constitute his or her usual and customary daily activities for more than 180 continuous days; or

(2) The medical and rehabilitation expenses of a victim or work loss of a victim exceeds the amount of personal injury protection benefits available.

(c) Nothing in subsection (b) of this section shall prevent the survivors of a victim whose death arises out of the maintenance or use of a motor vehicle from maintaining a civil action based on the liability of another person for the loss and noneconomic loss resulting from the victim's death regardless of whether the victim had previous to his or her death elected to receive personal injury protection benefits.

(d) The insurer must notify any identifiable victim in writing of the 60-day election period.

(e) The 60-day election period may be extended upon the mutual written agreement of the victim and the insurer.

(f) If a victim is incapacitated or in some other way unable to make the election, it may be made by the next closest relative, or if there is no relative, an individual taking responsibility for the victim's affairs.

(g) If the covered victim fails to make an election within the 60-day period, the mandatory liability insurance coverage applies.

(h) Except as provided in subsection (i) of this section, any person having a claim under the mandatory insurance required in § 31-2406 or the optional insurance offered pursuant to § 31-2404 may request that the claim be resolved by arbitration before the Board of Consumer Claims Arbitration for the District of Columbia, established by § 50-503. If the other party or parties to the action consent, the Board may hear and decide the matter. Arbitration of these claims shall be binding.

(i) Insurers shall arbitrate and settle all disputed claims made for automobile physical damage between them in accordance with the terms of the Nationwide Intercompany Arbitration Agreement ("Agreement") as adopted and from time to time amended by its members, and the rules promulgated pursuant to the Agreement, unless the parties mutually agree, on a per case basis, to use another arbitration forum, in which case the claim shall be arbitrated in that alternate forum. Mandatory arbitration of disputed claims shall be limited solely to the issues of liability and damages. Every automobile liability or physical damage insurer doing business in the District of Columbia shall be a member of the Nationwide Intercompany Arbitration Agreement sponsored by the Committee on Insurance Arbitration.

(Sept. 18, 1982, D.C. Law 4-155, § 6, 29 DCR 3491; Mar. 4, 1986, D.C. Law

6-96, § 2(d), 32 DCR 7245; Sept. 20, 1996, D.C. Law 11-160, § 2(a), 43 DCR 3722.)

Cross references. — Board of Consumer Claims Arbitration, see § 50-503.

Section references. — This section is referred to in § 31-2411.

Prior Codifications. — 1981 Ed., § 35-2105.

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-160. — Law 11-160, the "Automobile Amendment Act of 1996," was introduced in Council and assigned Bill No. 11-157, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on May 7, 1996, and June 4, 1996, respectively. Signed by the Mayor on June 26, 1996, it was assigned Act No. 11-296 and transmitted to both Houses of Congress for its review. D.C. Law 11-160 became effective on September 20, 1996.

Editor's notes. — Report by Commissioner of Insurance and Securities: Section 5 of D.C. Law 11-160 provided that "Within two years of September 20, 1996, the Commissioner of Insurance and Securities shall prepare and submit to the Council of the District of Columbia for its review a report on the impact of this act on the private passenger motor vehicle insurance market or any part thereof, the funding for the Office of Insurance, the District of Columbia insurance premium tax, the number of insurers doing business in the District, and the number of insurers domiciled in the District of Columbia. In preparing such report, the Commissioner may request from specific private passenger motor vehicle insurers doing business in the District, or from all such insurers, reasonable and pertinent information. Information which is proprietary to any affected insurer shall be treated as confidential by the Commissioner, but may be used in the aggregate with other information from other affected insurers for statistical or other reporting purposes."

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District of Columbia No-Fault Motor Vehicle Insurance Act barred injured bus driver's recovery for medical bills and lost wages from driver of vehicle which struck bus; under clear language of the statute, bus driver could maintain a civil action only for noneconomic loss. D.C. Code 1981, § 35-2105. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Compulsory/No-Fault Motor Vehicle Insurance Act barred pedestrian from bringing tort action against driver of car which struck her; pedestrian's exclusive remedy was personal injury protection benefits payable to her under driver's policy notwithstanding her argument

that she was not person to whom PIP benefits were payable because she did not own motor vehicle and was not beneficiary of PIP policy. D.C. Code 1981, § 35-2105(a); § 35-2106(d) (repealed). *Weeks v. Wimple*, 669 F. Supp. 499, 1987 U.S. Dist. LEXIS 8680 (1987).

Statutory exemption [D.C. Code 1981, § 35-2111(e)] of taxicabs from District of Columbia Compulsory/No Fault Motor Vehicle Insurance Act applies only to mandatory insurance provisions of Act, and does not prevent taxicab owner or driver from claiming benefits under no fault law, nor does it entitle him to avoid limitations on civil liability set forth in D.C. Code 1981, § 35-2105. *Arthur v. Avis Rent-A-Car System, Inc.*, 613 F. Supp. 82, 1985 U.S. Dist. LEXIS 24054 (1985).

To survive motion for directed verdict on ground that requisite statutory threshold for bringing tort action for noneconomic losses has not been satisfied, plaintiff must show that his injuries are such that reasonable persons could differ with regard to whether injuries fall within one of categories listed under no-fault statute. D.C. Code 1981, § 35-2105(b)(1). *State Farm Mut. Auto. Ins. Co. v. Hoang*, 682 A.2d 202, 1996 D.C. App. LEXIS 179 (1996).

Issue of whether plaintiff sustained "medically demonstrable _____ impairment"

necessary to maintain tort suit for noneconomic injuries arising from automobile accident was for jury, and not subject to directed verdict on issue of statutory threshold, based on testimony of plaintiff's neurologist and chiropractor that his impairment satisfied permanency and 180 continuous day standards, as corroborated by plaintiff's testimony concerning limitation of his activities and inability to perform his previous duties in upholstery business. D.C. Code 1981, § 35-2105(b)(1). *State Farm Mut. Auto. Ins. Co. v. Hoang*, 682 A.2d 202, 1996 D.C. App. LEXIS 179 (1996).

To survive summary judgment on claim that statutory threshold for bringing tort action for noneconomic losses has not been satisfied, plaintiff must make prima facie showing that injury falls within one of categories for satisfying threshold under no-fault statute. D.C. Code 1981, § 35-2105(b)(1). *State Farm Mut. Auto. Ins. Co. v. Hoang*, 682 A.2d 202, 1996 D.C. App. LEXIS 179 (1996).

Although No-Fault Act placed \$24,000 ceiling on the amount of lost wages that victim could recover as part of personal injury protection benefits, she could recover economic losses above that ceiling, and there was no violation of Rule 11 in filing complaint seeking those damages which included a claim for lost wages. D.C. Code 1981, § 35-2105(b)(1); Civil Rule 11. *Walker v. District of Columbia*, 656 A.2d 722, 1995 D.C. App. LEXIS 58 (1995).

No-Fault Act generally bars motorists who elect to receive personal injury protection benefits from pursuing private tort actions seeking damages for their injuries. D.C. Code 1981, § 35-2105(b). *Musa v. Continental Ins. Co.*, 644 A.2d 999, 1994 D.C. App. LEXIS 102 (1994).

Injuries to insured's foot sustained during automobile accident were not substantial impairment that had significant effect on insured's ability to perform his usual and customary activities, as required by No-Fault Act to pursue tort claim after receiving personal injury protection benefits, given that insured was able to continue enrollment as full-time college student and working as part-time security guard. D.C. Code 1981, § 35-2105(b). *Musa v. Continental Ins. Co.*, 644 A.2d 999, 1994 D.C. App. LEXIS 102 (1994).

Foot injuries insured sustained in automobile accident which forced insured to alter normal placement of his foot during walking did not significantly affect insured's ability to perform usual and customary activities, as required by No-Fault Act to bring tort suit after receiving personal injury protection benefits; insured continued to be enrolled as full-time college student. D.C. Code 1981, § 35-2105(b)(1). *Musa v. Continental Ins. Co.*, 644 A.2d 999, 1994 D.C. App. LEXIS 102 (1994).

Automobile accident victims' election to receive personal injury protection (PIP) benefits

from victim's insurer barred them from maintaining negligence action against second driver involved in collision, despite claim that statutory language "elect" required knowing, conscious and intelligent election to select PIP as remedy precluding other recovery, and that they did not intend to limit their right to file civil action; statute did suggest that election connoted anything more than choice and, moreover, insurer's letters to victims informed them that election of PIP benefits would cause them to lose right to make claim against other parties on basis of fault. D.C. Code 1981, § 35-2105(b). *Lee v. Jones*, 632 A.2d 113, 1993 D.C. App. LEXIS 260 (1993).

Even if automobile policy could be construed as being ambiguous as to whether insured's election of personal injury protection (PIP) benefits barred insured's suit against insurer for breach of contract in failing to pay uninsured motorist benefits based on liability of driver of unidentified vehicle allegedly involved in accident, any interpretation would yield to plain meaning of statute barring suit. D.C. Code 1981, § 35-2105. *Lee v. Jones*, 632 A.2d 113, 1993 D.C. App. LEXIS 260 (1993).

Personal injury protection (PIP) no-fault cover letter stating that once PIP payments were accepted, insured "loses the right to make a claim against all other parties on the basis of fault" was not ambiguous as to meaning of word "fault" or phrase "all other parties," so as to require extrinsic evidence to interpret policy in order to determine whether, having accepted PIP benefits, insured and second victim of automobile accident could bring claim against insurer for breach of contract in failing to pay uninsured motorist benefits based on liability of driver of unidentified vehicle allegedly involved in accident; both information provided by insurer and insurance contract were consistent with statute barring such suit. D.C. Code 1981, § 35-2105. *Lee v. Jones*, 632 A.2d 113, 1993 D.C. App. LEXIS 260 (1993).

Economic losses are payable, pursuant to Compulsory/No-Fault Motor Vehicle Insurance Act, as personal injury protection (PIP) benefits irrespective of whether tort was committed by insured against injured victim; however, victim must prove that insured was "at fault" in order to recover noneconomic losses after she first demonstrates that she meets exception to No-Fault Act's restrictions against tort claims. D.C. Code 1981, §§ 35-2104, 35-2105(b). *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Injured bus passenger failed to make prima facie showing that she suffered substantial permanent impairment or was virtually incapacitated for 180 continuous days after accident and thus failed to demonstrate that her cause of action against transit authority remained viable under exceptions to Compulsory/

No-Fault Motor Vehicle Insurance Act's restrictions against tort actions for noneconomic losses; fact that her back injury was relieved by aspirin indicated that injury was not "serious" within meaning of Act, and without sworn medical affidavits as to extent of her impairment for 180 days, her merely conclusory answers were inadequate to meet requisite "substantially all" exception to Act. D.C. Code 1981, § 35-2105(b). *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Motorist who failed to maintain insurance as required by No-Fault Act could not recover for noneconomic losses which were below threshold level of Act. D.C. Code 1981, § 35-2105(b)(6). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Construction and application.

Amendments to no-fault statute under challenge did not render moot appeal from portion of district court order striking down challenged provision where the preamendment statute still governed actions arising out of accidents occurring prior to the effective date of the amendment. D.C. Code 1981, § 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Eligibility for personal injury protection benefits under the Compulsory No-Fault Motor Vehicle Insurance Act was not fundamental right subject to protection of privileges and immunities clause. D.C. Code 1985 Supp. § 35-2106(e)(2); U.S. Const. Art. 4, § 2, cl. 1. *Davis v. District of Columbia Dept. of Consumer & Regulatory Affairs*, 561 A.2d 169, 1989 D.C. App. LEXIS 144 (1989).

Coverage.

Automobile accident victims, having elected to receive personal injury protection (PIP) benefits from victim's insurer, were statutorily barred from maintaining action against insurer for alleged breach of contract in failing to pay uninsured motorist benefits based on liability of driver of unidentified vehicle allegedly involved, despite claim that statute only restricted tort liability, i.e., "third party" liability in civil actions, and that contract action was "first-party civil action." D.C. Code 1981, § 35-2105. *Lee v. Jones*, 632 A.2d 113, 1993 D.C. App. LEXIS 260 (1993).

Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 did not require motorcyclist to be insured as precondition to recovery by motorcyclist of statutory personal injury protection benefits prior to Act's amendment in 1986 which thereafter included motorcycles in definition of motor vehicles under Act. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist who did not carry insurance on motorcycle was not entitled to recover personal injury protection benefits from insurer of his own automobile, as motorcyclist, who was a nonresident, was not operating his automobile in District at time of accident. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist whose motorcycle was not covered by insurance was entitled to recover statutory personal injury protection benefits from insurer for the automobile which was involved in accident with his motorcycle. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Intervening parties.

Insurer which sought to intervene in action challenging provisions of District of Columbia no-fault law only two days after district court clarified its ruling to indicate the effect of its holding acted timely. Fed. Rules Civ. Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Insurer which could not recoup, through an increase in premiums, additional costs which would result from invalidation of personal injury threshold for lawsuits under the District of Columbia no-fault law had inadequate interest in challenge to the law to intervene as of right. Fed. R. Civ. Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Because District of Columbia had no financial stake in outcome of challenge to provisions of no-fault law, it was inadequate representative of insurer which had based its premiums on the provisions of the law and the insurer was thus entitled to intervene as of right in action challenging constitutionality of the law. Fed. R. Civ. Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Medical expense threshold.

Medical expense threshold of \$5,000 imposed on personal injury suits by the District of Columbia No-Fault Act did not deny equal protection to those with lesser amounts of medical expenses and was rationally related to the desire to find a threshold that would at least approximate the line between those who are seriously injured and those who are not. D.C. Code 1981, § 35-2105(b)(6); U.S. Const. Amend. 5. *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Medical expense threshold requirement of \$5,000 for personal injury suits imposed by

District of Columbia no-fault law abolished a cause of action in tort for certain harm proximately caused by driver's negligence and did not merely alter the jurisdiction of the courts to hear such claims, and thus did not violate provision of the Self-Government Act prohibiting the District of Columbia from enacting any statute relating to the United States District Court for the District of Columbia. D.C. Code 1981, §§ 1-233(a)(4, 8), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Medical expense threshold of \$5,000 on personal injury suits imposed by District of Columbia no-fault law does not abrogate the right to jury trial in violation of the Seventh Amendment. D.C. Code 1981, § 35-2105(b)(6); U.S. Const. Amend. 7. *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Provision of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2105(b)(6)] barring suit for noneconomic loss unless medical expenses exceed \$5,000 violates equal protection rights embodied in the due process clause of the Fifth Amendment [U.S. Const. Amend. 5] as there is no basis for conclusion that claim for pain and suffering by motor vehicle accident victim whose medical expenses total \$4,500 is small and speculative and does not involve serious injury. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

The \$5,000 threshold amount for bringing suit under District of Columbia Compulsory/No Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2105(b)] is not unconstitutional; disagreeing with *Dimond v. District of Columbia*. *Arthur v. Avis Rent-A-Car System, Inc.*, 613 F. Supp. 82, 1985 U.S. Dist. LEXIS 24054 (1985).

Provisions of No-Fault Motor Vehicle Insurance Act that bar suits when medical expenses do not exceed \$5,000 and personal injury protection benefits are available are constitutional. D.C. Code 1981, § 35-2105(a); § 35-2105(b)(6) (1982). *Makanju v. Saunders*, 519 A.2d 703, 1987 D.C. App. LEXIS 268 (1987).

Noneconomic losses.

Automobile accident victim's inability to sue or recover the noneconomic losses arising from his automobile accident because of the threshold limits imposed by the District of Columbia no-fault law was a judicially cognizable injury providing him with standing to challenge substantive provisions of the law. D.C. Code 1981, § 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Injury resulting from inability to sue for noneconomic loss resulting from automobile accident because of District of Columbia no-fault law was not fairly traceable to any violation of District of Columbia Self-Government Act requirement that bill be read twice in substantially the same form prior to enactment, so that automobile accident victim did not have standing to challenge the no-fault law on that basis. D.C. Code 1981, §§ 1-229(a), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Noneconomic losses could be recovered by bringing tort action against driver "at fault" in automobile accident, but Compulsory/No-Fault Motor Vehicle Insurance Act restricted victim's ability to bring such actions; it is threshold question of law for court to decide whether party has met strict statutory requirements as set forth in No-Fault Act to overcome Act's restrictions against tort actions for noneconomic losses. D.C. Code 1981, §§ 35-2101 to 35-2113. *Smith v. Washington Metro. Area Transit Auth.*, 631 A.2d 387, 1993 D.C. App. LEXIS 231 (1993).

Motorist who failed to maintain insurance as required by No-Fault Act could not recover for noneconomic losses which were below threshold level of Act. D.C. Code 1981, § 35-2105(b)(6). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Punitive damages.

Claim for punitive damages by insured against auto insurer could not be maintained in what was essentially suit for breach of contract for payment of personal injury protection (PIP) benefits where, even if decision to terminate benefits was erroneous, nothing in record supported characterization of action as malicious, oppressive or made with willful disregard of insured's rights, so as to give insurer's actions color of willful tort. D.C. Code 1981, § 35-2105(b)(1). *State Farm Mut. Auto. Ins. Co. v. Hoang*, 682 A.2d 202, 1996 D.C. App. LEXIS 179 (1996).

Standing.

Automobile accident victim's inability to sue or recover the noneconomic losses arising from his automobile accident because of the threshold limits imposed by the District of Columbia no-fault law was a judicially cognizable injury providing him with standing to challenge substantive provisions of the law. D.C. Code 1981, § 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Injury resulting from inability to sue for noneconomic loss resulting from automobile accident because of District of Columbia no-fault law was not fairly traceable to any viola-

tion of District of Columbia Self-Government Act requirement that bill be read twice in substantially the same form prior to enactment, so that automobile accident victim did not have standing to challenge the no-fault law on that basis. D.C. Code 1981, §§ 1-229(a), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Statute of limitations.

Statute of limitations for maintaining action under Compulsory No-Fault Motor Vehicle Insurance Act begins to run when injured party knows, or exercising reasonable diligence should know, that party qualifies under one of six exceptions in Act, rather than on date of injury. D.C. Code 1981, §§ 12-301(8), 35-2105. *Stackhouse v. Schneider*, 559 A.2d 306, 1989 D.C. App. LEXIS 102 (1989).

Taxicabs.

"Exemption" of taxicabs from District of Columbia no-fault law applies only to mandatory insurance provision; exemption does not prevent a taxicab owner or driver from claiming benefits under the law, nor does it entitle him to avoid law's limitations on civil liability. D.C. Code 1981, §§ 35-2103, 35-2105. *Nasaka v. Data Access Systems*, 602 F. Supp. 761, 1985 U.S. Dist. LEXIS 22565 (1985).

Statutory exemption of taxicabs from provisions of No-Fault Act distinguishes between taxicabs and taxicab drivers and, as such, re-

fers only to mandatory insurance requirement for taxicabs, not to limitation on civil liability for taxicab drivers, and does not exempt drivers from limitation which No-Fault Act imposes on his or her common-law right to sue. D.C. Code 1981, §§ 35-2103(a), (d)(1)(A), 35-2111(e); § 35-2105(a) (1985). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

Taxicab driver who rented vehicle from cab company, though failing to maintain insurance for vehicle, was not an owner of vehicle required to provide and maintain personal injury protection benefits and, hence, was not ineligible for insurance under No-Fault Act and was therefore barred from maintaining a civil action based on liability against any person with respect to injury as to which personal injury protection benefits were payable. D.C. Code 1981, § 35-2105(a, b) (1985); § 35-2106(d, e) (repealed). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

Validity.

Provision of Compulsory No-Fault Motor Insurance Act making personal injury protection benefits unavailable to nonresidents was rationally related to objective of limiting recovery to residents and, therefore, did not violate principles of equal protection. D.C. Code 1985 Supp. §§ 35-2106(e)(2), 35-2108(a); U.S. Const. Amend. 5. *Davis v. District of Columbia Dept. of Consumer & Regulatory Affairs*, 561 A.2d 169, 1989 D.C. App. LEXIS 144 (1989).

§ 31-2406. Availability of required and optional insurance and benefits.

(a) *In general.* —

(1)(A) After consultation with insurers authorized to sell motor vehicle insurance in the District, the Commissioner shall from time to time approve, with any reasonable modifications, a reasonable plan or plans to assure the availability, to all owners of motor vehicles, of the insurance required to be maintained and of the insurance required to be offered by this chapter. The plan shall provide for suitable apportionment, by the manager or committee designated to operate the plan, among insurers of applicants for any of the insurance who are unable to obtain insurance reasonably through ordinary methods.

(B) When a plan has been approved by the Commissioner, all insurers authorized to sell motor vehicle insurance in the District shall subscribe thereto, cooperate therewith, and participate therein; provided, however, that no insurer shall be required to quote plan rates to applicants for voluntary insurance or to seek waivers from the plan before selling such voluntary insurance.

(C) Any applicant for a policy, any named beneficiary or insured under a policy issued pursuant to the plan, and any insurer may appeal to the

Commissioner from any decision of the manager or committee designated to operate the plan.

(D) Each insurer selling motor vehicle insurance in the District shall be required to offer insurance which shall provide at least all minimum benefits required by this chapter with respect to: (i) property damage liability; (ii) third-party personal liability; and (iii) uninsured motorist protection. In addition, each insurer shall offer optional personal injury protection insurance required by § 31-2404 and underinsured motor vehicle coverage as required by this section. Taxicab insurers and self-insurers shall be exempt from the requirement to offer optional personal injury protection insurance. Taxicab insurers and self-insurers shall also be exempt from the requirements of § 31-2404 that they offer uninsured motorist protection and underinsured motor vehicle coverage.

(2) Each insurer selling motor vehicle insurance in the District shall make the insurance policy understandable to policyholders. Each insurance company shall provide to policy holders at least annually the following information:

(A) A listing of each type of coverage available; and

(B) An explanation of the mandatory insurance and required options created under this chapter.

(2A) For policies issued or reissued after January 1, 2007, insurers shall be required to provide at least 2 copies of an Insurance Identification Card to the policyholder of the vehicle registered in the District of Columbia. The Insurance Identification Card must be carried in the insured motor vehicle for production upon demand. The insurer shall provide additional copies of the Insurance Identification card upon request of the insured.

(3), (4) Repealed.

(5) No insurer authorized to sell motor vehicle insurance in the District shall increase the rates charged an insured on account of an accident unless it is first determined that the accident was caused by the fault of the insured.

(b) *Property damage insurance.* — Property damage insurance shall provide that any liability to an insured to pay for property damage to any vehicle or other property not owned or controlled by the insured, in accordance with applicable law, shall be paid by the applicable insurer up to an amount requested by the named insured. The minimum amount of property damage liability insurance coverage that a named insured shall purchase is \$10,000 for property damage in any 1 accident.

(c) *Third-party personal liability.* — Third-party personal liability coverage shall provide that any liability of an insured to pay for injury arising from an accident within or outside the District of Columbia, in accordance with applicable law, shall be paid by the insurer up to the amount established in the policy. The minimum amount of 3rd-party personal liability coverage that an insured shall purchase shall be \$25,000 per person injured in any 1 accident and \$50,000 for all persons injured in any 1 accident.

(c-1) *Underinsured motor vehicle coverage.* — Underinsured motor vehicle coverage is for the protection of an insured who is legally entitled to recover damages from the owner or operator of an underinsured motor vehicle. Each

insurer shall offer, except for the operation of motorcycles, optional underinsured motor vehicle coverage in amounts up to the amounts of the uninsured motorist coverage as requested by the insured. Once an insured has rejected this underinsured motor vehicle coverage the insurer does not have to reoffer it. The insurer shall not be required to obtain or maintain written rejections of the underinsured motor vehicle coverage. The benefits provided by the underinsured motor vehicle coverage shall be subject to the same provisions as denials or exclusions of coverages, insolvency, subrogation, and set-off as provided in the uninsured motorist coverage. Nothing in this section shall prohibit the inclusion of underinsured motor vehicle coverage in any uninsured motor vehicle coverage provided in compliance with this chapter. Insurance that includes underinsured motor vehicle coverage may include terms and conditions that preclude stacking of underinsured motor vehicle coverage.

(d), (e) Repealed.

(f) *Mandatory uninsured motorist protection.* —

(1) For the purposes of this subsection, the term “uninsured motor vehicle” means a motor vehicle which:

(A) Is a motor vehicle which is not insured by a motor vehicle liability policy applicable to the accident;

(B) Is covered by a motor vehicle liability policy of insurance but the insurer denies coverage for any reason or becomes the subject of insolvency proceedings in any jurisdiction; or

(C) Is a motor vehicle which causes bodily injury or property damage and whose owner or operator cannot be identified.

(2) Each insurer selling motor vehicle insurance in the District with respect to any motor vehicle registered or principally garaged in the District shall include coverage for bodily injury or death in amounts of \$25,000 per person injured in any 1 accident, or \$50,000 for all persons injured in any 1 accident, and coverage for property damage in an amount of \$5,000 for property damage in any 1 accident for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles.

(3) Any payments for property damage made pursuant to this subsection shall be subject to a deductible amount of \$200.

(4) The named insured may require the issuance of coverage for bodily injury or death and property damage in accordance with a schedule of optional higher amounts up to the amount of \$100,000 per person injured in any 1 accident or \$300,000 for all persons injured in any 1 accident, and up to \$25,000 for property damages for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles.

(5) To the extent of any payment made to any person by the insurer under the coverage required by this section and subject to the terms and conditions of the coverage, the insurer is entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of any person against any other person legally responsible for the bodily injury or death for

which the payment is made, including any amount recoverable from an insurer which is or becomes the subject of an insolvency proceeding through such proceedings or in any other lawful manner.

(6) No insurer shall attempt to recover any amount against the insured of an insurer which is or becomes the subject of insolvency proceedings.

(7) Any motor vehicle policy of insurance may include terms and conditions that preclude stacking of uninsured motor vehicle coverages.

(g) *Prohibitions.* — A victim is prohibited from claiming personal injury protection benefits under this chapter, other than to compensate for any deductible, if the victim is eligible for compensation for the loss covered by personal injury protection from another insurer or another insurance coverage, unless the victim has exhausted benefits offered by the insurer or insurance coverage.

(h) *Additional reporting obligations.* — The Director may require a person whose driver's license or registration was revoked to obtain insurance coverage that includes additional reporting obligations, including SR 22 insurance coverage, prior to the issuance or reinstatement of a driver's license or registration, or both.

(Sept. 18, 1982, D.C. Law 4-155, § 7, 29 DCR 3491; Mar. 4, 1986, D.C. Law 6-96, § 2(e), 32 DCR 7245; Feb. 24, 1987, D.C. Law 6-192, § 19, 33 DCR 7836; Sept. 20, 1996, D.C. Law 11-160, § 2(b), 43 DCR 3722; May 21, 1997, D.C. Law 11-268, § 10(v), 44 DCR 1730; June 8, 2006, D.C. Law 16-117, § 201(b), 53 DCR 2548; Mar. 14, 2007, D.C. Law 16-279, § 101, 54 DCR 903; Mar. 25, 2009, D.C. Law 17-353, §§ 197(a), 246, 56 DCR 1117.)

Section references. — This section is referred to in §§ 5-114.01, 31-2402, 31-2403, 31-2404, 31-2405, and 31-2411.

Prior Codifications. — 1981 Ed., § 35-2106.

Effect of amendments. — D.C. Law 16-117 added par. (a)(2A).

D.C. Law 16-279 added subsec. (h).

D.C. Law 17-353, in subsec. (f)(1)(B), substituted "insurer denies coverage" for "insured denies coverage"; and validated previously made technical corrections in subsec. (h).

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 6-192. — Law 6-192, the "Technical Amendments Act of 1986," was introduced in Council and assigned Bill No. 6-544, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 5, 1986, and November 18, 1986, respectively. Signed by the Mayor on December 10, 1986, it was assigned Act No. 6-246 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-160. — For legislative history of D.C. Law 11-160, see Historical and Statutory Notes following § 31-2405.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2402.

Legislative history of Law 16-117. — For D.C. Law 16-117, see notes following § 31-2402.

Legislative history of Law 16-279. — Law 16-279, the "Department of Motor Vehicles Service and Safety Amendment Act of 2006", was introduced in Council and assigned Bill No. 16-821, which was referred to Committee on Public Works and Environment. The Bill was adopted on first and second readings on November 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28, 2006, it was assigned Act No. 16-636 and transmitted to both Houses of Congress for its review. D.C. Law 16-279 became effective on March 14, 2007.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

Editor's notes. — Report of the Commissioner of Insurance and Securities: Section 5 of D.C. Law 11-160 provided: "Within two years of

September 20, 1996, the Commissioner of Insurance and Securities shall prepare and submit to the Council of the District of Columbia for its review a report on the impact of this act on the private passenger motor vehicle insurance market or any part thereof, the funding for the Office of Insurance, the District of Columbia insurance premium tax, the number of insurers doing business in the District, and the number of insurers domiciled in the District of Columbia. In preparing such report, the Commissioner may request from specific private

passenger motor vehicle insurers doing business in the District, or from all such insurers, reasonable and pertinent information. Information which is proprietary to any affected insurer shall be treated as confidential by the Commissioner, but may be used in the aggregate with other information from other affected insurers for statistical or other reporting purposes."

Department of Insurance abolished: See Historical and Statutory Notes following § 31-2402.

CASE NOTES

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Civil actions.

Compulsory/No-Fault Motor Vehicle Insurance Act barred pedestrian from bringing tort action against driver of car which struck her; pedestrian's exclusive remedy was personal injury protection benefits payable to her under driver's policy notwithstanding her argument that she was not person to whom PIP benefits were payable because she did not own motor vehicle and was not beneficiary of PIP policy. D.C. Code 1981, § 35-2105(a); § 35-2106(d) (repealed). *Weeks v. Wimple*, 669 F. Supp. 499, 1987 U.S. Dist. LEXIS 8680 (1987).

Passenger's failure to join uninsured motorist as a party in passenger's suit against insurer seeking uninsured motorist benefits did not warrant dismissal of suit; insurer admitted that the uninsured motorist was the sole cause of the accident and that passenger was injured as a result of the accident, joining uninsured motorist as a defendant would have served no practical purpose, and insurer could show no prejudice from failure to join motorist. *Allstate Ins. Co. v. Ramos*, 782 A.2d 280, 2001 D.C. App. LEXIS 209 (2001).

District of Columbia resident who failed to maintain insurance paying personal injury protection benefits, as required by Compulsory/No-Fault Motor Vehicle Act, could not maintain negligence action against resident insured motorist to recover for injuries and damages suf-

fered in automobile accident in District of Columbia, including losses which would have been recoverable under insurance policy for payment of personal injury protection benefits. D.C. Code 1981, § 35-2106(d). *Monroe v. Foreman*, 540 A.2d 736, 1988 D.C. App. LEXIS 28 (1988).

Construction and application.

District of Columbia's no-fault motor vehicle insurance statute was not a public policy mandating pedestrian's recovery of uninsured motorist (UM) benefits under her Virginia policy without first obtaining a judgment against the driver. *Macci v. Allstate Ins. Co.*, 917 A.2d 634, 2007 D.C. App. LEXIS 72 (2007).

Given the stated legislative purpose of this Act, which was designed to provide adequate protection for victims who are injured in the District, it is reasonable to assume that references to "third-party" in subsection (a)(1)(D) and (c) were meant to refer to persons injured by an insured tortfeasor, as distinguished from coverage for the insured tortfeasor's own injuries. *State Farm Mut. Auto. Ins. Co. v. Smalls*, 121 WLR 117 (Super. Ct. 1992).

Coverage.

Under District of Columbia law, as predicted by federal district court, exclusion in automobile policy for "any person" using vehicle without reasonable belief that he was entitled to do so applied to insured's son; exclusion was not rendered ambiguous by provision in policy of coverage to insured and his family members for any auto accident, and while policy did not define term "any person" in exclusion, common, ordinary meaning of phrase was all persons, which necessarily included named insured and his family members. *Athridge v. Aetna Cas. & Sur. Co.*, 163 F.Supp.2d 38, 2001 U.S. Dist. LEXIS 21490 (2001), affirmed in part and reversed in part by, remanded by 351 F.3d 1166, 359 U.S. App. D.C. 22, 2003 U.S. App. LEXIS 24727 (2003).

Under District of Columbia law, insured is permitted to purchase uninsured motorist (UM) protection which protects person when he

is injured by uninsured motorist by providing him with insurance protection irrespective of fault, and thus, if insured is injured by uninsured motorist and has opted for UM coverage, insured recovers policy amount from his own insurance company. *Athridge v. Aetna Cas. & Sur. Co.*, 163 F.Supp.2d 38, 2001 U.S. Dist. LEXIS 21490 (2001), affirmed in part and reversed in part by, remanded by 351 F.3d 1166, 359 U.S. App. D.C. 22, 2003 U.S. App. LEXIS 24727 (2003).

Under District of Columbia law, when exclusion in automobile policy violates public policy because it conflicts with Compulsory No-Fault Motor Vehicle Insurance Act, insurance contract is deemed to provide victim with no more than statutory minimum amount which insured was required by law to carry. *Athridge v. Aetna Cas. & Sur. Co.*, 163 F.Supp.2d 38, 2001 U.S. Dist. LEXIS 21490 (2001), affirmed in part and reversed in part by, remanded by 351 F.3d 1166, 359 U.S. App. D.C. 22, 2003 U.S. App. LEXIS 24727 (2003).

Binder issued by insurance agency to applicant on date she initially applied for assigned risk coverage did not entitle applicant to coverage where she cancelled her application by specifically telling agency not to deposit or cash check and then submitted later application; under District of Columbia assigned risk plan, insurer who issued policy on second application could not be required to provide coverage on binder issued in connection with cancelled application. *Colonial Penn Ins. Co. v. Owens*, 728 F. Supp. 798, 1990 U.S. Dist. LEXIS 621 (1990).

Applicant's failure to disclose automobile accident that occurred approximately nine hours before she applied for coverage under District of Columbia assigned risk plan was a deliberate misrepresentation that rendered resulting automobile policy void from its inception. *Colonial Penn Ins. Co. v. Owens*, 728 F. Supp. 798, 1990 U.S. Dist. LEXIS 621 (1990).

Effective date and time of coverage specified in application for coverage under District of Columbia assigned risk plan controlled over date and time specified on declarations page of automobile policy; application stated in bold-face print that coverage would not be effective before date and hour of completion of application and, thus, policy did not cover automobile accident that occurred earlier on that day. *Colonial Penn Ins. Co. v. Owens*, 728 F. Supp. 798, 1990 U.S. Dist. LEXIS 621 (1990).

Driver who did not pay to renew automobile insurance policy before its expiration and died in motor vehicle accident the day after the policy expired did not accept insurer's offer of coverage, and, thus, no policy was in effect at time of accident, although insurer customarily allowed its insureds seven-day grace period, and driver had history of making late payments under his prior policies with insurer; customers

were not informed of period, there was no evidence that driver knew of it, it was only available to those who actually made payment within the period, and driver's death did not allow court to speculate that driver would have paid within the period had he lived. *Andrade-Sorto v. Allstate Ins. Co.*, 982 A.2d 669, 2009 D.C. App. LEXIS 501 (2009).

To the extent that an insurance policy with plaintiff's employer required contact between the insured and uninsured motor vehicles before coverage applied, it was inconsistent with the District's compulsory minimum automobile insurance laws and therefore unenforceable as against public policy. *Maddox v. Doe*, 122 WLR 69 (Super. Ct. 1993).

Federal preemption.

ERISA did not preempt statute which prohibits an insured from recovering personal injury protection (PIP) benefits, if the insured is eligible for compensation from another insurer or another insurance coverage; the statute governed the relationship between an insured and her automobile insurer, became relevant only after the ERISA plan paid medical expenses, had only an incidental effect on the plan, and, therefore, had only a tenuous, remote, or peripheral relationship to the plan. *Fisher v. Government Emples. Ins. Co.*, 762 A.2d 35, 2000 D.C. App. LEXIS 270 (2000).

Health insurance coverage.

At time of insured's motorcycle accident, insured was permitted double recovery for his medical expenses under his personal injury protection coverage and health insurance provided by his employer; statute at time of accident precluded double recovery specifically for social security, workers' compensation, temporary nonoccupational disability insurance, and any government program, but separate health insurance. D.C. Code 1981, §§ 35-2106(g), 35-2110(b). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

A health maintenance organization (HMO) is not an "insurer" within the meaning of a no-fault statute precluding the recovery of personal injury protection (PIP) benefits if the victim is eligible for compensation from another insurer; the no-fault act defines "insurer" as any self-insurer or any person, company, or professional association licensed to provide motor vehicle liability protection. *Carter v. State Farm Mut. Auto. Ins. Co.*, 808 A.2d 466, 2002 D.C. App. LEXIS 545 (2002).

A health maintenance organization (HMO) provides "insurance coverage" within the meaning of a no-fault statute precluding the recovery of personal injury protection (PIP) benefits if the victim is eligible for compensation from another insurer or another insurance coverage, even though the HMOs provide medical treat-

ment on a pre-paid basis; HMOs spread and underwrite risk. *Carter v. State Farm Mut. Auto. Ins. Co.*, 808 A.2d 466, 2002 D.C. App. LEXIS 545 (2002).

Household exclusion.

Household exclusion clause, which stated that there was no coverage for injury to insured or insured's family members, and which was contained in automobile policy of husband who was killed while his wife was driving vehicle, was invalid to the extent it conflicted with the District of Columbia's Compulsory No-Fault Motor Vehicle Insurance Act, which requires third-party personal liability coverage for the minimum amounts of \$25,000 per person and \$50,000 per accident; however, there was no bar to enforcement of household exclusion with respect to amounts greater than minimum statutory requirements. D.C. Code 1981, §§ 35-2106(c), 35-2109(l). *Smalls v. State Farm Mut. Auto. Ins. Co.*, 678 A.2d 32, 1996 D.C. App. LEXIS 129 (1996).

Motorcycles.

Failure of insured to pay on premiums for uninsured motorist protection for coverage of his motorcycle did not preclude insured from recovering uninsured motorist benefits, where at time of motorcycle accident, District of Columbia law required insurer to include coverage in every policy and precluded insured from rejecting that coverage. D.C. Code 1981, §§ 35-2103(a), 35-2106(f)(2). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Motorcycles and mopeds are insurable pursuant to No-Fault Act. D.C. Code 1981, § 35-2106(a)(3) (1984). *Townsend v. Waldo*, 640 A.2d 185, 1994 D.C. App. LEXIS 51 (1994).

Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 did not require motorcyclist to be insured as precondition to recovery by motorcyclist of statutory personal injury protection benefits prior to Act's amendment in 1986 which thereafter included motorcycles in definition of motor vehicles under Act. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist who did not carry insurance on motorcycle was not entitled to recover personal injury protection benefits from insurer of his own automobile, as motorcyclist, who was a nonresident, was not operating his automobile in District at time of accident. D.C. Code 1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Motorcyclist whose motorcycle was not covered by insurance was entitled to recover statutory personal injury protection benefits from insurer for the automobile which was involved in accident with his motorcycle. D.C. Code

1981, § 35-2101 et seq. *Coleman v. Cumis Ins. Soc.*, 558 A.2d 1169, 1989 D.C. App. LEXIS 98 (1989).

Nonresidents.

District of Columbia Compulsory No-Fault Motor Vehicle Insurance Act does not require foreign insurer to offer optional personal injury protection insurance to nonresident who is statutorily required to purchase other specified coverage as condition of operating motor vehicle in District of Columbia. D.C. Code 1981, §§ 35-2101 et seq., 35-2103(b). *Dove v. Dairyland Ins. Co.*, 562 A.2d 1199, 1989 D.C. App. LEXIS 153 (1989).

Provision of Compulsory No-Fault Motor Vehicle Insurance Act making personal injury protection coverage unavailable to nonresident did not unconstitutionally burden right to travel. D.C. Code 1985 Supp. § 35-2106(e)(2). *Davis v. District of Columbia Dept. of Consumer & Regulatory Affairs*, 561 A.2d 169, 1989 D.C. App. LEXIS 144 (1989).

Automobile policy purchased by District of Columbia motorist, which failed to provide coverage for nonresident, uninsured pedestrian injured in foreign state, did not violate District of Columbia No-Fault Act. D.C. Code 1981, § 35-2106(d) (repealed). *Taylor v. Canady*, 536 A.2d 93, 1988 D.C. App. LEXIS 7 (1988).

Uninsured, nonresident pedestrian injured in foreign state was not entitled to recover personal injury protection benefits under District of Columbia No-Fault Act, even though he was struck by District of Columbia motorist. D.C. Code 1981, § 35-2106(d) (repealed). *Taylor v. Canady*, 536 A.2d 93, 1988 D.C. App. LEXIS 7 (1988).

District of Columbia no-fault statute, rather than Maryland no-fault statute applied to actions filed by motorists, who sustained injuries in accidents in Maryland, where motorists resided, were licensed, and were registered to operate their motor vehicles in D. C., their vehicles were primarily garaged in D.C., and they purchased both their respective medical insurance and personal injury protections (PIP) insurance policies in D.C. *Turner v. State Farm Insurance Company*, 134 WLR 867 (, (Super. Ct. 2005)).

Out-of-state coverage.

Provisions of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, §§ 35-2103(a), 35-2106(c)] requiring resident motorist obtain out-of-state coverage and requiring insurers doing business in the District to provide out-of-state coverage do not deprive insureds of substantive due process by eliminating a freedom to choose the insurance protection best suited to the insured's needs. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681

(1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Provisions of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, §§ 35-2103(a), 35-2106(c)] which require residents to obtain out-of-state coverage and which require insurance companies doing business in the District to include out-of-state liability coverage do not burden interstate commerce in violation of the Commerce Clause [U.S. Const. Art. I, § 8, cl. 3]. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

District of Columbia motor vehicle owner who was required by law to purchase no-fault coverage for accidents that might occur outside of the District had standing to challenge constitutionality of that requirement of the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2106(c)]. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Presumptions and burden of proof.

Insured and occupants in insured's car were able to identify the driver of other car involved in accident, and thus, car was not presumed to be uninsured, even though evidence regarding the identity of driver was not admissible, where insured and occupants testified that they saw the license plate number of the other car that was involved in accident as it left the scene and wrote the number down, and insured testified that he identified the registered owner of the car. *Burke v. Md. Auto Ins. Fund*, 879 A.2d 996, 2005 D.C. App. LEXIS 413 (2005).

Self-insurers.

Error or negligence on part of government agency over which transit authority had no control would not estop authority from asserting statutory right not to provide uninsured motorist protection under District of Columbia law. D.C. Code 1981, §§ 35-2104, 35-2106(a)(1)(D), (c-1, f). *Coates v. Washington Metro. Area Transit Authority*, 742 F. Supp. 10, 1990 U.S. Dist. LEXIS 8794 (1990).

District of Columbia's Compulsory/No-Fault Motor Vehicle Insurance Act did not require qualified self-insurer, transit authority, to provide uninsured motorist protection. D.C. Code 1981, §§ 35-2104, 35-2106(a)(1)(D), (c-1, f). *Coates v. Washington Metro. Area Transit Authority*, 742 F. Supp. 10, 1990 U.S. Dist. LEXIS 8794 (1990).

Set-off.

A "set-off" provision in an insurance policy

may not operate to reduce the value of plaintiff's recovery on automobile liability policy below the statutory minimum. *Maddox v. Doe*, 122 WLR 69 (Super. Ct. 1993).

Subrogation of coverage.

An insurance carrier could draft a contract which provided for a reduction of the policy limit by any amount received in compensation for the injuries inflicted by an uninsured motorist, including workers' compensation. *Millender v. Nationwide Ins. Co.*, 119 WLR 1953 (Super. Ct. 1991).

Where an insurer provides for a reduction of the policy limit by any amount received as compensation for injuries, if such a contract fails to provide the mandatory minimum amount of coverage required of the insurer by the No-Fault Act because of such a reduction, the contract must yield to the statute, and the court may not enforce the contract to the extent that it violates the governing law. *Millender v. Nationwide Ins. Co.*, 119 WLR 1953 (Super. Ct. 1991).

Taxicabs.

Section of automobile policy barring uninsured motorist coverage for any vehicle used to carry persons for fee precluded uninsured motorist coverage for insured while he was driving his taxicab, despite his claim that coverage denial violated applicable statutory provisions and despite his reliance on out-of-state case law holding that uninsured motorist coverage was personal and traveled with insured. D.C. Code 1981, § 35-2106(a)(1)(D). *Hill v. Maryland Casualty Co.*, 620 A.2d 1336, 1993 D.C. App. LEXIS 43 (1993).

Holding company, which owned all the stock in three parent corporations which in turn owned 20 subsidiary taxi companies, had no legal interest in 1,438 taxicabs, which were operated by six different taxicab organizations controlled by the parent corporations, and holding company did not have any legal interest in the trade names and design displayed on the taxicabs; therefore, holding company was not the "owner" of the taxicabs, for purposes of District of Columbia statute, which permitted "owners" of taxicabs to set up sinking fund in lieu of obtaining insurance for the taxicabs. D.C. Code 1981, §§ 44-305(a)(2), 44-306. *Office of People's Counsel v. Public Service Com.*, 520 A.2d 677, 1987 D.C. App. LEXIS 280 (1987).

Holding company, which owned all the stock in three parent corporations which in turn controlled 1,438 taxicabs operated by six different taxicab associations each operating under different color scheme, did not own fleet of taxicabs having uniform color scheme, and thus, was not "company" within meaning of District of Columbia reporting regulations for taxicabs reporting under umbrella of single

"company"; therefore, holding company could not be required to comply with the reporting regulations, and compliance with the reporting regulations could not provide basis for permitting holding company to establish sinking fund in lieu of obtaining insurance for the taxicabs. D.C. Code 1981, §§ 44-305(a)(2), 44-306. Office of People's Counsel v. Public Service Com., 520 A.2d 677, 1987 D.C. App. LEXIS 280 (1987).

Taxicab driver who rented vehicle from cab company, though failing to maintain insurance

for vehicle, was not an owner of vehicle required to provide and maintain personal injury protection benefits and, hence, was not ineligible for insurance under No-Fault Act and was therefore barred from maintaining a civil action based on liability against any person with respect to injury as to which personal injury protection benefits were payable. D.C. Code 1981, § 35-2105(a, b) (1985); § 35-2106(d, e) (repealed). Johnson v. Collins, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

§ 31-2407. Priorities for the payment of personal injury protection benefits.

(a) The insurer responsible for the payment of personal injury protection benefits shall be determined in accordance with, and in the order of, priorities set forth in this section. The insurer liable to pay benefits is:

(1) The insurer providing personal injury protection insurance under which the victim is the named insured; or

(2) The insurer providing personal injury protection with respect to the motor vehicle in which, at the time of the accident, the victim is present.

(b) If 2 or more obligations to pay personal injury protection benefits apply equally to an injury, the insurer against which the claim is asserted first shall process and pay the claim as if wholly responsible, subject to subsequent contribution pro rata from any other insurer for the amount of benefits paid and for the cost of processing the claim.

(Sept. 18, 1982, D.C. Law 4-155, § 8, 29 DCR 3491; Mar. 4, 1986, D.C. Law 6-96, § 2(f), 32 DCR 7245.)

Prior Codifications. — 1981 Ed., § 35-2107.

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

§ 31-2408. Administration Fund. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-40, § 13(a), 40 DCR 6009.)

Prior Codifications. — 1981 Ed., § 35-2108.

Legislative history of Law 10-40. — Law 10-40, the "Insurance Regulatory Trust Fund Act of 1993," was introduced in Council and assigned Bill No. 10-93, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-75 and transmitted to both Houses of Congress for its review. D.C. Law 10-40 became effective on October 21, 1993.

§ 31-2408.01. Uninsured Motorist Fund.

(a) A fund is established in the District, to be known as the Uninsured

Motorist Fund ("Fund"), for the purpose of awarding compensation to a victim of an accident who sustains injury therefrom and would not otherwise be compensated for his or her loss. Assessment shall be made, on a fair and equitable basis, among all insurers in accordance with projections of the District government as to costs required for reasonable funding and administration of the Fund. The Fund shall be classified by the Mayor pursuant to § 47-375. The Fund shall be administered by the Mayor.

(1) All compensation awarded under this section shall be paid from the monies in the Fund.

(2) Monies in the Fund shall consist of, and there shall be deposited in the District of Columbia treasury to the credit of the Fund, monies received pursuant to subsection (a) of this section.

(b) A victim is eligible for compensation under this section subject to the following conditions:

(1) The accident upon which the claim is based was reported to the Mayor not more than 45 days after the accident occurred, except that this requirement may be waived for good cause shown.

(2) The victim files a claim on a form supplied by the Mayor and submits all required information and documents within 180 days after the accident, except that this requirement may be extended for good cause shown or if the victim is still undergoing medical treatment for injuries relating to the accident.

(3) The victim has suffered loss in an amount exceeding \$100 as a result of the accident upon which the claim is based.

(4) The victim shall be eligible if the only identifiable insurer or insurers, who would otherwise be obligated to compensate the victim, are financially unable to fulfill their obligations.

(c) The victim shall not be eligible if the victim is at fault, is an insured, owns a registered motor vehicle, or operated a motor vehicle in the accident upon which the claim is based.

(d) Claims shall be processed and maintained in the order of their filing.

(e) The amounts of compensation awarded shall be equal to the amount of the victim's loss, decreased by all amounts received by or available to the victim from collateral sources. No compensation shall be awarded pursuant to this section in an amount exceeding \$100,000 in medical and rehabilitative expenses, \$24,000 in wage loss, and \$4,000 in funeral expenses. No final award of compensation shall be made unless the Fund contains sufficient monies to pay the award.

(f) In addition to the amount of compensation awarded to a successful claimant, a reasonable fee may be awarded for any professional assistance required in connection with any claim under this section. The fee may not exceed 10% of the amount of the claimant's award or \$1,000, whichever is less.

(g)(1) Nothing in this section shall deprive the claimant or the claimant's successors in interest of the right to recover damages from the negligent party.

(2) The District of Columbia shall be subrogated to the claimant's right against the negligent party to the extent of any compensation awarded under this section. The District of Columbia may initiate a suit against the negligent

party for damages. The District of Columbia shall be notified by the plaintiff of the institution of any suit against the negligent party for damages. The District of Columbia shall have a lien on any recovery made from such a suit. All monies recovered through subrogation shall be deposited in the District of Columbia treasury to the credit of the Uninsured Motorist Fund.

(h) Any agreement by a person to waive, release, or commute his or her rights under this section is void. Compensation awarded under this section is exempt from execution, attachment, or other remedy for recovery or collection of debt, except for expenses resulting from injury or death which is the basis for the claim.

(i) Any person who knowingly submits false information in support of a claim under this section or knowingly suppresses relevant information concerning a claim under this section shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than \$2,000 or imprisoned for not more than 1 year, or both. A person convicted of an offense under this subsection shall forfeit any compensation under this section and shall reimburse and repay to the District of Columbia any compensation received pursuant to this section.

(j)(1) The Mayor shall administer the provisions of this section, and shall issue rules necessary to carry out the provisions and purposes of this section.

(2) The Mayor shall report annually to the Council of the District of Columbia on the status and activities of the Uninsured Motorist Fund. The report shall include, but is not limited to, the following information: Total number of claims filed, the number of claims approved and the amount of each award, the number of claims denied, the number of cases in which the claimant used professional assistance, the cumulative total of professional fees paid, the number of cases pending, and the future liability of the Uninsured Motorist Fund.

(Sept. 18, 1982, D.C. Law 4-155, § 9a, as added Mar. 4, 1986, D.C. Law 6-96, § 2(h), 32 DCR 7245.)

Prior Codifications. — 1981 Ed., § 35-2114.

Legislative history of Law 6-96. — Law 6-96, the “Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 Amendments Act of 1985,” was introduced in Council and assigned Bill No. 6-249, which was referred to the Com-

mittee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 5, 1985, and November 19, 1985, respectively. Signed by the Mayor on November 22, 1985, it was assigned Act No. 6-104 and transmitted to both Houses of Congress for its review.

CASE NOTES

ANALYSIS

Collateral sources of compensation.
Noneconomic losses.
Validity.

Collateral sources of compensation.

Passenger who was not covered by automobile policy was not “insured” within meaning of uninsured motorist compensation fund statute, and her health insurance did not disqualify her from receiving compensation under statute; health insurance was relevant, however, as it

constituted potential collateral source for her medical expenses and might require reduction in ultimate recovery. D.C. Code 1981, §§ 35-2102(10, 11), 35-2114(c, e). *Tesfamariam v. District of Columbia Dep’t of Consumer & Regulatory Affairs*, 645 A.2d 1105, 1994 D.C. App. LEXIS 130 (1994).

Sum, designated as being solely for pain and suffering, received by injured passenger in settlement by suit against uninsured motorist who caused her injuries, was a “collateral source” that reduced the amount of entitlement avail-

able to passenger from Uninsured Motorist Fund. D.C. Code 1981, § 35-2114. *Daniel v. District of Columbia Ins. Admin.*, 639 A.2d 590, 1994 D.C. App. LEXIS 45 (1994).

identified and insured. D.C. Code 1981, §§ 35-2101 to 35-2114. *Thomas v. Washington Metropolitan Area Transit Authority*, 846 F.2d 1536, 1988 U.S. App. LEXIS 7100 (C.A.D.C. 1988).

Noneconomic losses.

Bus passenger injured by unidentified motorist could not recover uninsured motorist benefits from self-insured bus company where passenger's medical expenses did not exceed statutory threshold for recovering noneconomic losses against motorist if he or she had been

Validity.

Statute governing recovery from Uninsured Motorist Fund is not unconstitutionally vague. D.C. Code 1981, § 35-2114; U.S. Const. Amend. 14. *Daniel v. District of Columbia Ins. Admin.*, 639 A.2d 590, 1994 D.C. App. LEXIS 45 (1994).

§ 31-2409. Consumer protection.

(a) *Grounds for cancellation of policy.* — No insurer shall cancel a policy except:

(1) For refusal or failure of the insured to pay a premium due under the terms of the policy of motor vehicle insurance;

(2) Where the motor vehicle registration certificate of the insured has been suspended or revoked during the period of the policy of motor vehicle insurance; or

(3) Where the license of an insured has been suspended or revoked during the period of a policy of motor vehicle insurance, the insurance shall not provide coverage for such insured during the period of suspension or revocation.

(b) *Notice required of cancellation of or refusal to renew policy.* —

(1) No cancellation or refusal to renew by an insurer of a policy of motor vehicle insurance shall be effective unless the insurer has delivered or mailed to the named insured, at his or her last known address, a written notice of intent to cancel or refusal to renew. The required notice shall be provided to the named insured at least 30 days prior to the effective date of cancellation, or in the case of nonrenewal, 30 days prior to the end of the policy period. The notice shall contain a statement:

(A) Of the specific reasons relied upon by the insurer as the basis of cancellation or refusal to renew;

(B) Advising the named insured of his or her right to request, in writing, within 15 days of receipt of the notice, that the Commissioner review the action of the insurer in cancelling or refusing to renew the policy of the insured;

(C) Advising the insured of the possible availability of other insurance which may be obtained through his or her agent, through another insurer, or through the District of Columbia Automobile Insurance Plan; and

(D) That the motor vehicle registration or reciprocity sticker of the vehicle shall be suspended or revoked for failure to maintain required insurance.

(2)(A) Or, in the case of a refusal or failure of the insured to pay a premium due under the terms of the policy, the notice shall be provided to the insured not less than 15 days prior to the effective date of the cancellation, or in the event of a cancellation or nonrenewal for refusal or failure or an insured to pay a premium due under the terms of the policy, within 15 days of receipt of the notice.

(B) The provisions of subparagraph (A) of this paragraph may take effect when the Director of the Department of Motor Vehicles certifies, as published in the District of Columbia Register, that the automated systems and procedures of the Department reasonably permits implementation of this change, but not later than October 1, 2002. Insurance companies shall file with the Commissioner by June 30, 2004, a report on the industry-wide economic impact, if any, of this section on the insurance premium downpayment for purchasing automobile coverage to residents of the District of Columbia with a goal of contributing to an overall reduction in the premium downpayment of 10% from the date of the implementation of subsection (b) of this section. The Commissioner shall issue a report to the Council on the overall industry reduction in the insurance premium payment on or before September 1, 2004. In the event the industry-wide insurance premium downpayment reduction is less than 10%, the report shall state the reasons why the decrease is less than the goal.

(c) *Proof of mailing notice.* — Proof of mailing of the notice of cancellation, or of intention not to renew, to the named insured by post office receipt secured or certified mail at the address shown in the policy or to the named insured's last known address, shall be sufficient proof of notice.

(d) *Consequences of failure to provide required notice.* — Despite failure of the named insured to make timely payment of the renewal premium, failure by the insurer to provide the notice required by this section shall result in the insurer being required:

(1) To provide coverage for any claim which would have been covered under the policy, if a claim arises within 45 days after the date within which the named insured discovers or should have discovered that his or her policy has not been renewed; and

(2) To renew the policy upon tender of payment; provided, that tender is made within 15 days after the date the named insured discovers, or should have discovered, that his or her policy has not been renewed.

(e) *Prohibited discrimination.* — No insurer, other than a self-insurer, shall fail or refuse to issue a policy of motor vehicle insurance to an applicant, fail or refuse to renew a policy of motor vehicle insurance, or cancel a policy of motor vehicle insurance for any reason provided in Unit A of Chapter 14 of Title 2.

(f) *Prohibited inquiries concerning prior cancellation or nonrenewals.* — No applicant for a policy of motor vehicle insurance, as a condition precedent to obtaining a policy or renewing a policy, shall be required to disclose whether he, she, or any person reasonably expected to operate the applicant's motor vehicle has ever had an insurance policy cancelled or nonrenewed; provided, however, that at the time of application an applicant may be required to disclose his or her experience as an operator of a motor vehicle for a past period of not more than 3 years, and that of any person reasonably expected to operate the motor vehicle.

(g) *Refusal to accept brokerage business.* — An insurer or agent that accepts brokerage business and rejects the business of a broker shall provide the Mayor and the broker, upon the request of the broker, the reasons in writing for such rejection.

(h) *Policies in effect less than 60 days.* — The restrictions on cancellation contained in this section shall not be effective with respect to any policy which shall have been in force for 60 days or less if the policy is not a renewal policy.

(i) *Appeal procedure.* —

(1)(A) If the insured disputes the validity of a purported cancellation or nonrenewal, the insured may send, within 15 days of receipt of the notice of intent to cancel or not to renew, written notification to the Commissioner of the reasons the insured believes the action by the insurer is invalid. The Commissioner shall, upon receipt, immediately send the insurer a copy of the notification; or

(B) In the event of a cancellation or nonrenewal for refusal or failure of an insured to pay a premium due under the terms of the policy, within 15 days of receipt of the notice of intent to cancel or not to renew.

(C) The provisions of subparagraph (A) of this paragraph may take effect when the Director of the Department of Motor Vehicles certifies, as published in the District of Columbia Register, that the automated systems and procedures of the Department reasonably permits implementation of this change, but not later than October 1, 2002. Insurance companies shall file with the Commissioner by June 30, 2004, a report on the industry-wide economic impact, if any, of this section on the insurance premium downpayment for purchasing automobile coverage to residents of the District of Columbia with a goal of contributing to an overall reduction in the premium downpayment of 10% from the date of the implementation of subsection (b) of this section. The Commissioner shall issue a report to the Council on the overall industry reduction in the insurance premium payment on or before September 1, 2004. In the event the industry-wide insurance premium downpayment reduction is less than 10%, the report shall state the reasons why the decrease is less than the goal.

(2) Unless the matter referred to in paragraph (1) of this subsection has been settled, the Commissioner shall determine, within 45 days calendar days, whether the cancellation or nonrenewal was authorized under the terms of this section and shall notify immediately the insured and the insurer in writing of the decision.

(3) If the Commissioner determines that a policy was improperly cancelled or not renewed, the policy in question shall be considered to be in effect and to have been in effect from the period of notification of cancellation or nonrenewal. If the Commissioner determines that a policy was properly cancelled or not renewed, the policy in question shall be considered to be cancelled or not renewed as of the cancellation or nonrenewal date given in the notice sent by the insurer pursuant to this section or as of the date of determination by the Commissioner, whichever is later. The insured shall pay any portion of the required premium or cost to the insurer for the insurance coverage in effect and provided by the insurer for which the insured has not paid.

(4) Decisions of the Commissioner shall be appealable pursuant to subchapter I of Chapter 5 of Title 2.

(j) *Immunity.* — There shall be no liability on the part of and no cause of action of any nature shall arise against any employee of the District govern-

ment, any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation who, in good faith:

- (1) Furnishes to the named insured information as to reasons for cancellation or nonrenewal;
- (2) Makes any statement in any written notice of cancellation or renewal;
- (3) Makes any other communication, oral or written, specifying the reasons for cancellation or nonrenewal;
- (4) Provides information pertaining to the insured; or
- (5) Makes statements or submits evidence at any hearing conducted in connection therewith.

An insurer may request the disclosure for a period exceeding 3 years for the sole purpose of providing a discount on the premium or cost of the motor vehicle insurance at the request of the insured.

(k) *Other rights.* — The rights provided by this chapter shall be in addition to and shall not prejudice any other rights the named insured may have at common law or otherwise.

(l) *Terms more favorable; prohibition of waiving rights.* — A policy may provide terms more favorable to named insureds than are required by this chapter, but no policy shall contain any provisions which waives any of the requirements of this chapter.

(m) *Consumer's right to information.* — A copy of the provisions of this section shall be provided, in writing, by the insurer to the named insured at the time of the initial purchase of insurance, or in the case of insurance renewal, provided, in writing, to the named insured by the insurer at the time of the 1st renewal after September 18, 1982.

(n) *Nondiscrimination against persons not previously insured.* — No insurer shall refuse to insure, refuse to continue to insure, limit coverage available to, or charge a disadvantageous rate to any person seeking to obtain insurance required by this chapter because that person had not been previously insured. This provision shall not apply if the applicant was required by law to maintain automobile insurance coverage and failed to do so. An insurer may require reasonable proof that the applicant did not fail to maintain this coverage. The insurer is not required to accept the mere lack of a conviction or citation for failure to maintain this coverage as proof of maintenance of coverage.

(o) *Insurer to provide settlement.* — Each insurer shall, at the time of renewal or denial of a motor vehicle insurance policy, provide to an applicant a statement which provides the following information:

- (1) If requested by the policyholder, the cost of the minimum package of insurance required by this chapter; and
- (2) In the case of a denial, specific reasons for the denial.

(Sept. 18, 1982, D.C. Law 4-155, § 10, 29 DCR 3491; Mar. 4, 1986, D.C. Law 6-96; § 2(i), 32 DCR 7245; Sept. 20, 1996, D.C. Law 11-160, § 2(c), 43 DCR 3722; May 21, 1997, D.C. Law 11-268, § 10(v), 44 DCR 1730; Apr. 13, 1999, D.C. Law 12-209, § 401, 45 DCR 8433; Apr. 27, 2001, D.C. Law 13-289, § 101(c), 48 DCR 2057.)

Section references. — This section is referred to in § 31-2411.

Prior Codifications. — 1981 Ed., § 35-2109.

Effect of amendments. — D.C. Law 13-289 rewrote subs. (b) and (i)(1) which had read:

“(b) Notice required of cancellation of or refusal to renew policy.— No cancellation or refusal to renew by an insurer of a policy of motor vehicle insurance shall be effective unless the insurer has delivered or mailed to the named insured, at his or her last known address, a written notice of intent to cancel or refusal to renew. The required notice shall be provided to the named insured at least 30 days prior to the effective date of cancellation, or in the case of nonrenewal, 30 days prior to the end of the policy period. The notice shall contain the following:

“(1) A statement of the specific reason or reasons relied upon by the insurer as the basis of cancellation or refusal to renew;

“(2) A statement advising the named insured of his or her right to request, in writing, within 15 days of receipt of the notice, that the Commissioner review the action of the insurer in cancelling or refusing to renew the policy of such insured;

“(3) A statement advising the insured of the possible availability of other insurance which may be obtained through his or her agent, through another insurer, or through the District of Columbia Automobile Insurance Plan; and

“(4) A statement that the motor vehicle registration of the vehicle will be cancelled or revoked for failure to maintain required insurance.”

“(1) If the insured disputes the validity of a purported cancellation or nonrenewal, the insured may, within 15 days of receipt of the notice of intent to cancel or not to renew, send written notification to the Commissioner of the reasons the insured believes the action by the insurer is invalid. The Commissioner shall, upon receipt, immediately send the insurer a copy of the notification.”

Temporary Amendment of Section. — For temporary (225 day) amendment to section, see § 501 of Health Insurance Portability and Accountability Federal Law Conformity, Motor Vehicle Insurance, Regulatory Reform, and Consumer Law Temporary Amendment Act of 1998 (D.C. Law 12-154, September 18, 1998, law notification 45 DCR 6951).

Emergency legislation. — For temporary amendment of section, see § 13 of the Reciprocal Insurance Company Conversion Emergency Amendment Act of 1998 (D.C. Act 12-298, March 4, 1998, 45 DCR 1775).

For temporary amendment of section, see § 501 of the Health Insurance Portability and Accountability Federal Law Conformity Emer-

gency Amendment Act of 1998 (D.C. Act 12-339, May 4, 1998, 45 DCR 2947), and § 501 of the Health Insurance Portability and Accountability Federal Law Conformity, Motor Vehicle Insurance, Regulatory Reform, and Consumer Law Congressional Review Emergency Amendment Act of 1998 (D.C. Act 12-429, August 6, 1998, 45 DCR 5890).

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-160. — For legislative history of D.C. Law 11-160, see Historical and Statutory Notes following § 31-2405.

Legislative history of Law 12-209. — Law 12-209, the “Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998,” was introduced in Council and assigned Bill No. 12-419, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second reading on July 7, 1998, and September 22, 1998, respectively. Signed by the Mayor on October 16, 1998, it was assigned Act No. 12-496, and transmitted to both Houses of Congress for review. D.C. Law 12-209 became effective on April 13, 1999.

Legislative history of Law 13-289. — For D.C. Law 13-289, see notes following § 31-2402.

Editor’s notes. — Near the middle of paragraph (2) of subsection (i), the phrase “45 days calendar days” is set forth exactly as enacted by D.C. Law 6-96.

Report of the Commissioner of Insurance and Securities: Section 5 of D.C. Law 11-160 provided that “Within two years of September 20, 1996, the Commissioner of Insurance and Securities shall prepare and submit to the Council of the District of Columbia for its review a report on the impact of this act on the private passenger motor vehicle insurance market or any part thereof, the funding for the Office of Insurance, the District of Columbia insurance premium tax, the number of insurers doing business in the District, and the number of insurers domiciled in the District of Columbia. In preparing such report, the Commissioner may request from specific private passenger motor vehicle insurers doing business in the District, or from all such insurers, reasonable and pertinent information. Information which is proprietary to any affected insurer shall be treated as confidential by the Commissioner, but may be used in the aggregate with other

information from other affected insurers for statistical or other reporting purposes.”

Department of Insurance abolished: See His-

torical and Statutory Notes following § 31-2402.

CASE NOTES

ANALYSIS

Grounds for cancellation.

Notice of cancellation.

Remedies.

Grounds for cancellation.

Under District of Columbia law, driver whose motor vehicle operator's permit had been suspended, was not covered by motor vehicle policy at time of accident which occurred while her permit was suspended under D.C. Code 1981, § 35-2109(a)(3), which provides that motor vehicle policy shall not provide coverage for insured during period his license is suspended or revoked, even though driver had not been directly notified that her license was suspended, but only of suspension which would occur unless she applied for hearing, and driver had not been notified that due to the suspension, she was not covered under motor vehicle policy. D.C. Code 1981, § 35-2109(b). *Johnson v. Cumis Ins. Soc.*, 624 F. Supp. 1170, 1986 U.S. Dist. LEXIS 30443 (1986).

Notice of cancellation.

D.C. Code 1981, § 35-2109(b), which requires insurer to provide notice of cancellation at least 30 days prior to effective date, does not apply to “suspensions” of no-fault automobile coverage effected under D.C. Code 1981, § 35-2109(a)(3), which provides that motor vehicle policy shall not provide coverage for insured during period insured's license has been suspended or revoked. *Johnson v. Cumis Ins. Soc.*, 624 F. Supp. 1170, 1986 U.S. Dist. LEXIS 30443 (1986).

Purpose of D.C. Code 1981, § 35-2109(b), which requires insurer to provide notice of cancellation at least 30 days prior to effective date, is to give insured adequate time to procure new coverage before coverage under his old motor vehicle policy lapses. *Johnson v. Cumis Ins. Soc.*, 624 F. Supp. 1170, 1986 U.S. Dist. LEXIS 30443 (1986).

Administrative law judge of the Department of Consumer and Regulatory Affairs had jurisdiction to adjudicate claims brought by insured against his former insurer for alleged violation of 30-day notice provision for cancellation of automobile liability policy and failure to provide insured with a copy of statute under “consumer protection” statute, which was a part of

the compulsory no-fault motor vehicle insurance statute, even though the proceeding was instituted pursuant to the Consumer Protection Procedures Act, and the claims made were not listed in the “unlawful trade practices” enumerated in the Act. D.C. Code 1981, §§ 28-3901 to 28-3908, 35-2101 et seq., 35-2109, 35-2109(b, m). *Atwater v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

Cancellation of automobile policy was not void due to failure to give 30-day notice of cancellation, where the insured should have known that his coverage had lapsed for nonpayment of premiums, in that the insured had not made any payments for insurance since his initial payment over five months before the accident for which the insured was making a claim. D.C. Code 1981, §§ 35-2109, 35-2109(b, d, m). *Atwater v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

Insured was not entitled to notice of cancellation of policy from insurer, where the insured had executed a power of attorney and interposed a premium finance company between himself and the insurer, and where the cancellation took place at the request of the finance company. D.C. Code 1981, §§ 35-1561, 35-1561(c), 35-2109, 35-2109(b). *Atwater v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

Remedies.

Remedies available under the Consumer Protection Procedures Act (CPPA) are broader than those under the No-Fault Motor Vehicle Insurance Act, in that under the No-Fault Act if it is determined that a policy was improperly cancelled the insurer is required to pay all the claims for which it would be liable under the policy, while under the CPPA, an administrative law judge may not only grant the relief available from the insurance administration, but may also issue a cease and desist order, award contract damages and restitution, impose costs, and grant preventive relief against future violations. D.C. Code 1981, §§ 28-3905(g), 35-2109(d)(1), (i)(3), (k). *Atwater v. District of Columbia Dep't of Consumer & Regulatory Affairs*, 566 A.2d 462, 1989 D.C. App. LEXIS 209 (1989).

§ 31-2410. Special provisions.

(a) *Election of deductible.* — An insurer offering to provide personal injury protection insurance in the District may offer, at appropriately reduced premium rates, a deductible of a specified dollar amount up to the amount prescribed by the Mayor, upon the recommendation of the Commissioner. This deductible may be applicable to all or any specified type of personal injury protection benefit, except that it may not be made applicable to any medical, paramedical, ambulance, or hospital services furnished to a victim on an emergency basis during the 72 hours immediately following an accident.

(b) *Subtraction of certain other benefits.* — All benefits (less reasonably incurred collection costs) that an individual receives or may receive, with respect to an injury, from:

- (1) Repealed;
- (2) Workers' compensation;
- (3) Temporary nonoccupational disability insurance that is required by a state or the District government; and
- (4) Repealed;

shall be subtracted in calculating personal injury protection benefits unless the law authorizing or providing for those benefits makes them secondary to or duplicative of personal injury protection benefits.

(c) *Penalty for overdue payment of personal injury protection benefits.* —

(1) All personal injury protection benefits are payable as loss accrues, subject to receipt by the applicable insurer of reasonable proof of the fact and amount of loss sustained. If personal injury protection benefits are not paid within 30 days after receipt of such proof, the payment is overdue.

(2) An overdue payment of personal injury protection benefits bears interest at the prime rate of interest generally prevailing in the District on the date upon which such payment is first overdue per annum from the date upon which such payment is first overdue.

(3) For purposes of this subsection, payment is made on the date a draft or other valid commercial instrument is placed in the United States mail in a properly addressed and posted envelope or on the date of delivery thereof, whichever is applicable.

(d) *Assignment of rights to future benefits.* — An agreement for the assignment of a right to any personal injury protection benefits payable in the future is void.

(e) *Payment of attorneys fees.* —

(1) An attorney may receive a reasonable fee for advising and representing a claimant in an action for personal injury protection benefits which are overdue. The fee shall be paid by the applicable insurer in addition to the amount of the personal injury protection benefits which are overdue and the penalty under subsection (c) of this section if a court finds that the insurer did not promptly pay the amount due.

(2) An insurer may be allowed, by a court, an award of a reasonable sum for a fee for its attorney for the legal cost of defending against a claim that is or was fraudulent in some significant respect. The award may be treated as an

offset against the amount of any personal injury protection benefits then or thereafter owing by that insurer to the person making that claim.

(f) *Primacy of personal injury protection.* — Repealed.

(Sept. 18, 1982, D.C. Law 4-155, § 11, 29 DCR 3491; Mar. 14, 1985, D.C. Law 5-159, § 13(b), 32 DCR 30; Mar. 4, 1986, D.C. Law 6-96, § 2(j), 32 DCR 7245; May 21, 1997, D.C. Law 11-268, § 10(v), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 32(a), 45 DCR 745; Apr. 20, 1999, D.C. Law 12-264, § 37, 46 DCR 2118.)

Section references. — This section is referred to in § 31-2411.

Prior Codifications. — 1981 Ed., § 35-2110.

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 5-159. — For legislative history of D.C. Law 5-159, see Historical and Statutory Notes following § 31-2403.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2402.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill

No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 12-264. — Law 12-264, the "Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998," was introduced in Council and assigned Bill No. 12-804, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on November 10, 1998, and December 1, 1998, respectively. Signed by the Mayor on January 7, 1999, it was assigned Act No. 12-626, and transmitted to both Houses of Congress for review. D.C. Law 12-264 became effective on April 20, 1999.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2402.

CASE NOTES

ANALYSIS

Attorney fees.
Construction and application.
Health insurance.
Standing.
Workers' compensation.

Attorney fees.

Attorneys' efforts to prove insurer acted in bad faith were not compensable in light of fact that claimant had to prove only that insurer did not promptly pay amount due, and not that insurer acted in bad faith, in order to be awarded attorney fees. D.C. Code 1981, § 35-2110(e)(1). *Messina v. Nationwide Mut. Ins. Co.*, 998 F.2d 2, 1993 U.S. App. LEXIS 16202 (C.A.D.C. 1993).

Construction and application.

Nothing in this chapter or in its legislative history demonstrates a legislative intent to compensate a victim without a preliminary finding that the accident, itself, caused the

injury in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

In paragraph (c)(1), the phrase "proof of the fact _____ of loss sustained" can only mean proof of the fact of loss sustained because of the subject accident; thus, the insurer being asked to pay is first entitled to reasonable proof of causality. If, after good faith consideration of that proof, the insurer is not satisfied that the presumed loss resulted from the subject accident, it is not required to pay the benefits in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

Health insurance.

At time of insured's motorcycle accident, insured was permitted double recovery for his medical expenses under his personal injury protection coverage and health insurance provided by his employer; statute at time of accident precluded double recovery specifically for social security, workers' compensation, temporary nonoccupational disability insurance, and

any government program, but separate health insurance. D.C. Code 1981, §§ 35-2106(g), 35-2110(b). *Tapscott v. Dairyland Ins. Co.*, 673 F. Supp. 611, 1987 U.S. Dist. LEXIS 10479 (1987).

Standing.

Plaintiffs who did not have claim for benefits under the District of Columbia Compulsory/No-Fault Motor Vehicle Insurance Act [D.C. Code 1981, § 35-2110(b)(4)] reduced because of receipt of government benefits and who had not been threatened with such a reduction did not have standing to challenge the constitutionality of the provision. *Dimond v. District of Columbia*, 618 F. Supp. 519, 1984 U.S. Dist. LEXIS 10681 (1984), affirmed in part and reversed in part by 792 F.2d 179, 253 U.S. App. D.C. 111, 1986 U.S. App. LEXIS 25293 (1986).

Workers' compensation.

Exclusivity clause of Workers' Compensation Act did not bar employee from seeking benefits from employer under No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-304. *Holmes v. Washington Metro. Area Transit Authority*, 731 F. Supp. 1115, 1990 U.S. Dist. LEXIS 889 (1990).

In situations in which the District of Columbia No-Fault Motor Vehicle Insurance Act and the District of Columbia Workers' Compensation Act apply, benefits payable under workers' compensation are primary over benefits payable under no-fault; thus, personal injury protection benefits must be paid by a self-insured employer only if benefits paid under workers' compensation do not accord an injured individual the full measure of recovery he would receive from PIP benefits. D.C. Code 1981, §§ 35-2101 to 35-2113, 35-2110(b, f), 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Workers' compensation benefits paid by an employer which satisfy in whole or in part the personal injury protection benefits which self-

insured employer must pay under the District of Columbia No-Fault Motor Vehicle Insurance Act are effectively PIP payments; thus, employer who has paid workers' compensation benefits that partially or fully satisfy the required PIP benefits may obtain reimbursement from the insurer of a liable third party. D.C. Code 1981, § 35-2111(d). *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Under the District of Columbia No-Fault Motor Vehicle Insurance Act, self-insured employer of injured bus driver had a right of reimbursement from liable third parties for workers' compensation payments which were effectively personal injury protection payments to driver, regardless of source, subject to a determination of fault. D.C. Code 1981, § 35-2111. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Although benefits payable under workers' compensation are primary over personal injury protection benefits payable under the District of Columbia No-Fault Motor Vehicle Insurance Act, remedies under workers' compensation allowing an employer to recoup benefits paid from liable third parties are not primary over the remedies set forth in the No-Fault Act; in situations where both no-fault and workers' compensation apply, an employer may recoup benefits paid under workers' compensation only through avenues provided by the No-Fault Act. D.C. Code 1981, §§ 35-2101 to 35-2113, 36-301 to 36-344. *McCrae v. Marques*, 688 F. Supp. 653, 1988 U.S. Dist. LEXIS 9490 (1987).

Comprehensive Merit Personnel Act entitled District of Columbia, as employer, to reimbursement for workers' compensation payments made to employees from tort recoveries for those same injuries, regardless of nature of damages recovered by employees from third parties. D.C. Code 1981, § 1-624.32. *Lee v. District of Columbia*, 559 A.2d 308, 1989 D.C. App. LEXIS 104 (1989).

§ 31-2411. Miscellaneous provisions.

(a) Statute of limitations. —

(1) Except as otherwise provided in this subsection, a civil action for the recovery of any personal injury protection benefits payable under this chapter shall be commenced not later than 3 years after the date of the injury giving rise to entitlement to such benefits.

(2) If an appropriate written notice setting forth the name and address of the victim and the time, place, and nature of the injury is given to the insurer or any of its authorized agents reasonably promptly after the date of the accident resulting in the injury, a civil action may be commenced at any time within 3 years after the date such a notice is given by a person claiming to be entitled to personal injury protection benefits or by a person acting on behalf of a victim. If the applicable insurer makes any payment of benefits for

personal injury protection with respect to a particular victim and injury, then a civil action may be commenced at any time within 3 years after the most recent payment.

(b) *Physical or mental examination of victim.* —

(1) If a person's physical or mental condition is material to any claim that has been made or that may be made for personal injury protection benefits, the person involved shall submit to physical or mental examination by physicians, in accordance with provisions of the policy of insurance pursuant to which a claim has been or may be made. A policy of insurance providing for payment of the benefits required for personal injury protection may include reasonable provisions for physical and mental examination of persons claiming any such benefits.

(2)(A) If requested by the person examined, a copy of every written report concerning an examination under this subsection which is made by an examining physician shall be delivered or mailed to such person without charge.

(B) At least 1 report shall set forth in detail the findings and conclusions of the examining physicians.

(C) Upon request and delivery or mailing, the party causing a person to be examined under this subsection may request the person examined to furnish its representative with a copy of every written report available to that person concerning any examination which is relevant to that person's claim for personal injury protection benefits.

(D) An applicable insurer may request a person claiming personal injury protection benefits to submit the name and address of each physician, medical-care facility, hospital, clinic, rehabilitation center, nursing facility, or other person or institution that has diagnosed or treated the victim for or with respect to the injury claimed and any relevant past injury, as a prerequisite to the payment of benefits under this chapter.

(E) A person shall authorize an insurer to inspect and copy records relevant to such a claim which are prepared or maintained by any physician, hospital, clinic, rehabilitation center, nursing facility, or other person or institution.

(3) A court may make any order which is just in case a person refuses to comply with any provision of paragraph (1) or (2) of this subsection, except that an order shall not be entered directing the arrest of a person for disobeying an order to submit to a physical or mental examination.

(4) Nothing contained in this subsection shall preclude a victim from obtaining treatment by the victim's own physician.

(c) *Good-faith mistake.* —

(1) Payment of personal injury protection benefits by an insurer in good faith to or for the benefit of a person believed to be entitled thereto discharges the insurer from its obligation to the extent of the amount of such payment, unless such insurer has been notified in writing prior to the payment of the claim of some other person.

(2) If there is doubt about the proper person to receive the benefits involved or the proper apportionment to be made among the persons entitled

to benefits or about whether an item of medical or rehabilitation expense was reasonably necessary or whether the charge for an item is reasonable, the insurer, the claimant, or any other interested person may apply to the Superior Court of the District of Columbia for an appropriate order. If an application is made by an insurer before the benefit claimed is overdue, the provisions of § 31-2410(c) and (e) are not applicable with respect to the amount.

(d) *Subrogation.* —

(1) An insurer shall have a right of reimbursement from any other insurer, based upon a determination of fault, for any personal injury protection benefits paid or obligated to be paid by that insurer as a result of an accident that involved 2 or more motor vehicles, at least 1 of which was of a type other than a passenger motor vehicle.

(2) An insurer which has paid or become obligated to pay personal injury protection benefits in any case not covered by paragraph (1) of this subsection may agree to receive a right of reimbursement from any other insurer with respect to some or all of those benefits.

(3) Entitlement to reimbursement and the amount of any reimbursement under this subsection shall be determined by agreement between any insurers who are involved under paragraph (1) of this subsection or who agree under paragraph (2) of this subsection. If the insurers fail to reach agreement as to entitlement or amount or both, these issues shall be determined by intercompany arbitration in accordance with any applicable agreement between the insurers involved under procedures established by the Commissioner. The determination of any right of reimbursement under this subsection shall not be affected by the provisions of § 31-2405.

(e) *Waiver for taxicabs.* —

(1) Taxicabs shall be waived from the mandatory minimum insurance requirements of § 31-2406 (except for the provisions of § 31-2409) for 2 years from March 4, 1986. The Mayor shall gradually increase minimum liability insurance requirements for taxicabs during the waiver period, after hearings held in accordance with § 2-509.

(2) The rate of increase will be determined by the Mayor based upon evidence submitted to the Mayor on the reasonableness of the insurance rate and liability limit increase in relation to the need to preserve the economic viability of the taxi industry.

(3) The Mayor shall impose the liability limits and rate increases on an annual basis.

(4) Two years from March 4, 1986, the owners and operators of taxis shall be required to obtain mandatory insurance as set forth in § 31-2406.

(5) Nothing in this section shall preclude the owner or operator of a taxi from carrying insurance greater than the required minimum or from carrying at his or her option personal injury protection benefits.

(f) *Rulemaking.* — The Mayor, the Director, or the Commissioner, or each of them, may, in accordance with § 2-509, issue rules to expeditiously and economically administer this chapter.

(Sept. 18, 1982, D.C. Law 4-155, § 12, 29 DCR 3491; Mar. 4, 1986, D.C. Law

6-96, § 2(k), 32 DCR 7245; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 32(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-2111.

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2402.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2410.

Transfer of Functions. — See Historical and Statutory Notes following § 31-2402.

Editor's notes. — Exemption of taxicabs from certain provisions of Law 4-155: See Mayor's Order 83-176, June 30, 1983.

CASE NOTES

ANALYSIS

Coverage.

Statute of limitations.

Taxicabs.

Coverage.

Nothing in this chapter or in its legislative history demonstrates a legislative intent to compensate a victim without a preliminary finding that the accident, itself, caused the injury in question. *Edmonds v. Stonewall/Dixie Ins. Co.*, 114 WLR 961 (Super. Ct. 1986).

Statute of limitations.

In action alleging breach of contract and bad faith brought by insured against insurer, insured failed to produce evidence of any affirmative inducement, or representations or promises made by insurer that would have tolled statute of limitations which began to run on date claim was first denied; insurer reconsidered and denied insured's claim approximately one month before statute of limitations expired and insured never contended that insurer ever acknowledged any indebtedness, made any promise to pay, requested that insured forebear from bringing suit, admitted liability, or engaged in settlement discussions. D.C. Code 1981, § 35-2111(a)(2). *Jones v. Government Employees Ins. Co.*, 621 A.2d 845, 1993 D.C. App. LEXIS 57 (1993).

Taxicabs.

Statutory exemption [D.C. Code 1981, § 35-2111(e)] of taxicabs from District of Columbia Compulsory/No Fault Motor Vehicle Insurance Act applies only to mandatory insurance provisions of Act, and does not prevent taxicab owner or driver from claiming benefits under no fault

law, nor does it entitle him to avoid limitations on civil liability set forth in D.C. Code 1981, § 35-2105. *Arthur v. Avis Rent-A-Car System, Inc.*, 613 F. Supp. 82, 1985 U.S. Dist. LEXIS 24054 (1985).

Although interpretation of District of Columbia no-fault law by Office of Insurance Superintendent of the District was not binding on district court on issue whether taxicab driver was entitled to avoid limitations on civil liability set forth in law, it was entitled to considerable deference. D.C. Code 1981, § 35-2101 et seq. *Nasaka v. Data Access Systems*, 602 F. Supp. 761, 1985 U.S. Dist. LEXIS 22565 (1985).

"Exemption" of taxicabs from District of Columbia no-fault law applies only to mandatory insurance provision; exemption does not prevent a taxicab owner or driver from claiming benefits under the law, nor does it entitle him to avoid law's limitations on civil liability. D.C. Code 1981, §§ 35-2103, 35-2105. *Nasaka v. Data Access Systems*, 602 F. Supp. 761, 1985 U.S. Dist. LEXIS 22565 (1985).

Taxi cab exemption in No-Fault Motor Vehicle Insurance Act does not permit taxi cab driver to maintain civil action. D.C. Code 1981, § 35-2111(e). *Makanju v. Saunders*, 519 A.2d 703, 1987 D.C. App. LEXIS 268 (1987).

Statutory exemption of taxicabs from provisions of No-Fault Act distinguishes between taxicabs and taxicab drivers and, as such, refers only to mandatory insurance requirement for taxicabs, not to limitation on civil liability for taxicab drivers, and does not exempt drivers from limitation which No-Fault Act imposes on his or her common-law right to sue. D.C. Code 1981, §§ 35-2103(a), (d)(1)(A), 35-2111(e); § 35-2105(a) (1985). *Johnson v. Collins*, 516 A.2d 196, 1986 D.C. App. LEXIS 456 (1986).

§ 31-2412. Temporary Motor Vehicle Insurance Review Commission [Expired].

Expired.

Prior Codifications. — 1981 Ed., § 35-2112.

Editor's notes. — Expiration of Temporary Motor Vehicle Insurance Review Commission: Pursuant to subsection (i) of former § 35-2112

1981 Ed., the Temporary Motor Vehicle Insurance Review Commission was to expire 3 years after March 4, 1986. The Temporary Motor Vehicle Insurance Review Commission is deemed to have expired on March 4, 1989.

§ 31-2413. Penalties; adjudications.

(a) A person is guilty of an offense if that person:

(1) Makes any false material statement with respect to his or her compliance with the obligation to maintain required insurance;

(2) Is the owner of a motor vehicle that is required to be registered or obtain a reciprocity sticker in the District and required insurance is not in effect with respect to that motor vehicle;

(3) Is the owner of a motor vehicle and operates or permits that motor vehicle to be operated in the District without required insurance being in effect with respect to that motor vehicle;

(4) Repealed.

(5) Operates a motor vehicle as to which the certificate of registration or reciprocity sticker has been suspended pursuant to § 31-2403(d)(2);

(6) Fails or refuses to return or give a registration certificate, reciprocity sticker, or tags to the Department, an authorized agent of the Department, or to a law-enforcement officer;

(7) Fails or refuses to present an Insurance Identification Card, its equivalent in another state, or other evidence establishing that required insurance is in effect with respect to a motor vehicle operated by that person upon demand by a law-enforcement officer; or

(8) Violates any other provision of this chapter.

(a-1) A violation of subsection (a)(7) of this section shall create a rebuttable presumption of a violation of subsection (a)(3) of this section.

(b)(1)(A) A person who commits an offense under subsection (a)(3) of this section shall be subject to both the regulatory scheme established in § 31-2403(d)(2) and to a civil fine of \$500, or a license suspension for up to 30 days, or both, for the first offense, and an increase of 50% of the civil fine for the second and each subsequent offense, or a license suspension for up to 60 days, or both, pursuant to §§ 50-2301.04 and 50-2301.05.

(B) A motor vehicle owner or operator shall be permitted to contest by mail or in person the charge of operating or permitting to be operated a motor vehicle without required insurance being in effect with respect to that motor vehicle pursuant to subsection (a)(3) of this section. For the purposes of contesting the charge, the owner or operator shall be permitted to present as evidence establishing that the required insurance was in effect with respect to the motor vehicle any of the following:

(i) An Insurance Identification Card;

(ii) An insurance policy;

(iii) Any other evidence that constitutes reasonable proof that the required insurance was in effect; or

(iv) Copies of any documents described in sub-subparagraphs (i) through (iii) of this subparagraph.

(C) Unless the hearing examiner has reasonable doubt about the veracity of the evidence presented pursuant to subparagraph (B)(i) and (ii) of this paragraph, submission of either shall be sufficient to dismiss the charge of operating or permitting to be operated a motor vehicle without required insurance being in effect with respect to that motor vehicle pursuant to subsection (a)(3) of this section.

(2)(A) In addition to the regulatory scheme established in § 31-2403(d)(2) for a person who commits an offense under subsection (a)(2) of this section a civil fine of \$150 shall be assessed for each vehicle without the required insurance for a period of 1 to 30 days, and increasing to \$7 for each day thereafter, not to exceed a total of \$2,500 for each violation pursuant to § 31-2404(d)(2)(A) [sic]. All or part of any penalty may be waived by the Director upon submission or proof that the vehicle was not operated during the corresponding time period.

(B) A person shall not be subject to a fine pursuant to this paragraph if the person believed, in good faith, that the person contracted for the required insurance coverage with a company which subsequently went out of business or otherwise failed to comply with this law.

(3) A person who commits an offense under subsection (a)(7) of this section shall be subject both to the regulatory scheme established in § 31-2403(d)(2) and to a civil fine of \$30.

(c) In addition to the penalties provided in subsection (b)(1) of this section, a person who commits an offense under subsection (a)(1), (5), (6), or (8) of this section shall upon conviction also be subject to imprisonment for not more than 30 days for the 1st offense, and imprisonment for not more than 90 days for the 2nd and subsequent offenses.

(d) All fines paid for violations of subsection (a) of this section shall be placed in the General Fund of the District of Columbia.

(Sept. 18, 1982, D.C. Law 4-155, § 15, 29 DCR 3491; Mar. 10, 1983, D.C. Law 4-199, § 3, 30 DCR 119; Sept. 27, 1985, D.C. Law 6-38, § 2, 32 DCR 4307; Mar. 4, 1986, D.C. Law 6-96, § 2(m), 32 DCR 7245; Mar. 23, 1995, D.C. Law 10-253, § 103, 42 DCR 721; Sept. 26, 1995, D.C. Law 11-52, § 103, 42 DCR 3684; Apr. 27, 2001, D.C. Law 13-289, § 101(d), 48 DCR 2057; June 8, 2006, D.C. Law 16-117, § 201(c), 53 DCR 2548; Mar. 14, 2007, D.C. Law 16-279, § 204, 54 DCR 903; July 18, 2008, D.C. Law 17-197, § 10(b), 55 DCR 6277; Sept. 14, 2011, D.C. Law 19-21, § 9050(b), 58 DCR 6226.)

Cross references. — Hearing examiners and traffic adjudication, see § 50-2301.04.

Monetary sanctions and traffic adjudication, see § 50-2301.05.

Unauthorized use of motor vehicles, see § 22-3215.

Section references. — This section is referred to in §§ 3-1357, 5-114.02, 31-2403, and 50-2302.05.

Prior Codifications. — 1981 Ed., § 35-2113.

Effect of amendments. — D.C. Law 13-289

rewrote subsec. (b), par. (2)(A) which had read:

"(2)(A) In addition to being subject to the regulatory scheme established in § 31-2403(d)(2), for a person who commits an offense under subsection (a)(2) of this section a civil fine of \$500 for the 1st violation and \$1000 for the 2nd and subsequent violations, with applicable penalties and fees, may be imposed pursuant to Chapter 23 of Title 50."

D.C. Law 16-117, in par. (a)(3) deleted "knowingly" preceding "operates"; repealed par. (a)(4); in par. (a)(7), substituted "an Insurance Identification Card, its equivalent in another state, or other evidence establishing" for "evidence"; added subsec. (a-1), subpars. (b)(1)(B) and (b)(1)(C), and par. (b)(3); and rewrote and designated the existing text of par. (b)(1) as subpar. (b)(1)(A).

D.C. Law 16-279, in subsec. (b)(2)(A), added a sentence to the end of the subparagraph relating to the waiver of all or part of any penalty.

D.C. Law 17-197 added subsec. (d).

D.C. Law 19-21, in subsec. (d), substituted "General Fund of the District of Columbia" for "Motor Vehicle Theft Prevention Fund established by § 3-1356".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 103 of Multiyear Budget Spending Reduction and Support Temporary Act of 1995 (D.C. Law 10-253, March 23, 1995, law notification 42 DCR 1652).

Emergency legislation. — For temporary amendment of section, see § 103 of the Omnibus Budget Support Congressional Review Emergency Act of 1995 (D.C. Act 11-124, July 27, 1995, 42 DCR 4160).

Legislative history of Law 4-155. — For legislative history of D.C. Law 4-155, see Historical and Statutory Notes following § 31-2401.

Legislative history of Law 4-199. — Law 4-199, the "Christmas Tree Act of 1982," was introduced in Council and assigned Bill No. 4-427, which was referred to the Committee on Human Services. The Bill was adopted on first and second readings on November 16, 1982, and December 14, 1982, respectively. Signed by the Mayor on December 28, 1982, it was assigned Act No. 4-283 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-38. — Law 6-38, the "District of Columbia Traffic Amendment Act of 1985," was introduced in Council

and assigned Bill No. 6-12, which was referred to the Committee on the Judiciary. The Bill was adopted on first and second readings on June 11, 1985, and June 25, 1985, respectively. Signed by the Mayor on July 11, 1985, it was assigned Act No. 6-56 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-96. — For legislative history of D.C. Law 6-96, see Historical and Statutory Notes following § 31-2408.01.

Legislative history of Law 11-52. — Law 11-52, the "Omnibus Budget Support Act of 1995," was introduced in Council and assigned Bill No. 11-218, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on April 19, 1995, and June 6, 1995, respectively. Signed by the Mayor on July 13, 1995, it was assigned Act No. 11-94 and transmitted to both Houses of Congress for its review. D.C. Law 11-52 became effective on September 26, 1995.

Legislative history of Law 13-289. — For D.C. Law 13-289, see notes following § 31-2402.

Legislative history of Law 16-117. — For D.C. Law 16-117, see notes following § 31-2402.

Legislative history of Law 16-279. — Law 16-279, the "Department of Motor Vehicles Service and Safety Amendment Act of 2006", was introduced in Council and assigned Bill No. 16-821, which was referred to Committee on Public Works and Environment. The Bill was adopted on first and second readings on November 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28, 2006, it was assigned Act No. 16-636 and transmitted to both Houses of Congress for its review. D.C. Law 16-279 became effective on March 14, 2007.

Legislative history of Law 17-197. — Law 17-197, the "Motor Vehicle Theft Prevention Act of 2008", was introduced in Council and assigned Bill No. 17-138 which was referred to the Committee on Public Safety and Judiciary. The Bill was adopted on first and second readings on April 1, 2008, and May 6, 2008, respectively. Signed by the Mayor on May 23, 2008, it was assigned Act No. 17-394 and transmitted to both Houses of Congress for its review. D.C. Law 17-197 became effective on July 18, 2008.

Legislative history of Law 19-21. — For history of Law 19-21, see notes under § 31-107.

CHAPTER 25. FIRE, CASUALTY, AND MARINE INSURANCE.

Subchapter I. Applicability; Definitions

Sec.

- 31-2501.01. Short title.
 31-2501.02. Applicability of chapter.
 31-2501.03. Definitions.

Subchapter II. Powers and Duties of the Commissioner

- 31-2502.01. Records of Commissioner; rules and regulations.
 31-2502.02. Certificate of authority to do business — Issuance or renewal.
 31-2502.03. Certificate of authority to do business — Revocation or suspension.
 31-2502.04. Cessation of business.
 31-2502.05 to 31-2502.07. [Repealed].
 31-2502.08. [Repealed].
 31-2502.09. Making or publishing material false statements.
 31-2502.10. [Repealed].
 31-2502.11. Kinds of insurance authorized.
 31-2502.12. Limitations on exposure to risks or hazards.
 31-2502.13. Minimum capital and surplus requirements.
 31-2502.14. Applicability of provisions to existing companies.
 31-2502.15. Formation of domestic companies.
 31-2502.16. [Repealed].
 31-2502.17. Power of domestic mutual companies to borrow or assume liability.
 31-2502.18. [Repealed].
 31-2502.19. Exclusive agency contracts of domestic companies.
 31-2502.20. Authority to transact business — Foreign or alien companies.

Sec.

- 31-2502.20a. Authority to transact business — Lloyd's organizations.
 31-2502.21. Procurement of certificate of authority by foreign or alien companies — Application forms.
 31-2502.22. Procurement of certificate of authority by foreign or alien companies — Delivery of certain documents to Commissioner; required showings; authorized examinations.
 31-2502.23. [Repealed].
 31-2502.24. Names or designations used by mutual companies and reciprocal or interinsurance exchanges.
 31-2502.25. Premiums of mutual companies.
 31-2502.26. [Repealed].
 31-2502.26a. Actuarial opinion of reserves.
 31-2502.26b. Confidentiality of actuarial opinions, summaries, reports, and workpapers.
 31-2502.27. Filing and approval of policy forms.
 31-2502.28. Rate and form filing requirements for accident and health policies.
 31-2502.29. Discriminations prohibited.
 31-2502.30. [Repealed].
 31-2502.31. Compensation of unlicensed persons prohibited.
 31-2502.32 to 31-2502.37. [Repealed].
 31-2502.38. Exceptions to licensing provisions.
 31-2502.39. Persons not to act for unauthorized companies.
 31-2502.40. License to procure policies from unauthorized companies.
 31-2502.41. License fees.
 31-2502.42. Violations of provisions.
 31-2502.43 to 31-2502.45. [Repealed].

*Subchapter I. Applicability; Definitions.***§ 31-2501.01. Short title.**

This chapter shall be known as the "Fire and Casualty Act."

(Oct. 9, 1940, 54 Stat. 1063, ch. 792, ch. I, § 1.)

Prior Codifications. — 1981 Ed., § 35-1501. 1973 Ed., § 35-1301.

§ 31-2501.02. Applicability of chapter.

All fire, marine, and casualty insurance companies now or hereafter incorporated or formed in the District or authorized to do business in the District, all brokers and all agents and other representatives of such companies shall, to the extent hereinafter provided, be subject to this chapter; provided, that

this chapter shall not affect the business of life and title insurance, and shall not affect the right or authority of any solvent company to make contracts of fidelity or surety, and shall not affect a plan under which any person provides pension benefits to his employees.

(Oct. 9, 1940, 54 Stat. 1064, ch. 792, ch. I, § 2.)

Prior Codifications. — 1981 Ed., § 35-1502. 1973 Ed., § 35-1302.

§ 31-2501.03. Definitions.

In this chapter, unless the context otherwise requires:

- (1) "District" means District of Columbia.
- (2) "Mayor" means the Mayor of the District of Columbia.
- (3) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking or the officer or officers, agency or agencies succeeding to his functions under Reorganization Plan No. 5 of 1952.
- (4) "Department" means the Department of Insurance of the District of Columbia.
- (5) "Company" means an insurance, surety, or indemnity company, and shall be deemed to include a corporation, company, partnership, association, individual, or aggregation of individuals engaging in or proposing or attempting to engage in any kind of insurance, surety, or indemnity business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.
- (6) "Authorized company" means a company which has authority from the Commissioner to do business in the District as provided under § 31-2502.02.
- (7) "Unauthorized company" means a company which does not have authority from the Commissioner to do business in the District as provided under § 31-2502.02.
- (8) "Domestic company" means a company incorporated or organized under the laws of the District.
- (9) "Foreign company" means a company incorporated or organized under the laws of any state of the United States.
- (10) "Alien company" means a company incorporated or organized under the laws of any country other than the United States.
- (11) "Reciprocal" includes interinsurance exchange.
- (12) "Person" includes individuals, corporations, associations, exchanges, and partnerships.
- (13) Personal pronouns include all genders; the singular includes the plural and the plural includes the singular.
- (14) "Policy" means an insurance policy or contract, including contracts of fidelity and surety, and includes any contract wherein 1 party called the "company," for a consideration, undertakes to pay money or its equivalent, or to do an act valuable to any other party, upon the happening of the hazard or peril insured against whereby the party insured suffers loss or injury or is subjected to legal liability.

(15) "Officer," when used to refer to officer of the company, includes an attorney-in-fact.

(16) "Policy-writing agent" means any person who is not a salaried employee of a company, and whose residence or principal place of business is located in the District, and who is authorized in writing by any company authorized to transact business in the District to countersign policies and to solicit, negotiate, or effect contracts of insurance, surety, or indemnity for such company in the District.

(17) "Soliciting agent" means any person who is not a salaried employee of a company and whose residence or principal place of business is located in the District, and who is authorized by a company having authority to transact business in the District, or by a policy-writing agent, to solicit in the District contracts of insurance, surety, or indemnity in behalf of such company or agent.

(18) "Broker" means any person who for a consideration acts or aids in any manner in the solicitation or negotiation on behalf of the assured of contracts of insurance, surety, or indemnity.

(19) "Salaried company employee" means any person regularly employed by an authorized company, and who is paid a regular wage or salary to perform certain duties and functions authorized by such company. For the purposes of this chapter the term "salaried company employee" shall not include employees engaged solely in office duties or in the inspection, rating, or classifying of risks or in the supervision of agents, or any employee not engaged in the solicitation or writing of policies, or officers of companies or associations engaged in the performance of their usual and customary executive duties.

(20) "Surplus" means the excess of admitted assets over liabilities and capital in the case of a company with capital stock, and the excess of admitted assets over liabilities in the case of a company without capital stock.

(21) "Liabilities" means all debts due or to become due, contingent or otherwise, of which the company has knowledge, and includes the reserves required by this chapter.

(22) "Admitted assets" includes the investments authorized or permitted pursuant to the National Association of Insurance Commissioners Accounting Practices Manual.

(Oct. 9, 1940, 54 Stat. 1064, ch. 792, ch. I, § 3; June 30, 1953, 67 Stat. 120, ch. 168; Feb. 27, 1996, D.C. Law 11-90, § 9(a), 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(r)(1), 44 DCR 1730; Apr. 13, 2005, D.C. Law 15-354, § 47, 52 DCR 2638.)

Cross references. — Additional definition of "company," see § 31-2502.39.

Section references. — This section is referred to in §§ 22-3225.01 and 31-701.

Prior Codifications. — 1981 Ed., § 35-1503.

1973 Ed., § 35-1303.

Effect of amendments. — D.C. Law 15-354, in par. (3), substituted "of the Department

of Insurance, Securities, and Banking" for "of Insurance and Securities".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 9(a) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 10(a) of the Insur-

ance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 9(a) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 11-90. — Law 11-90, the “Insurance Omnibus Insurance Amendment Act of 1995,” was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Editor’s notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all

functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Construction and application.
Insurance.

Construction and application.

The legislation relating to insurance in District of Columbia is so elaborate that court is not inclined to strain its coverage to include an activity left uncovered by the ordinary meaning of language used. D.C. Code 1961, §§ 35-102, 35-105, 35-202, 35-1320, 35-1321. Metropolitan

Police Retiring Ass’n v. Tobriner, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

Insurance.

“Insurance” involves essentially a contractual security against anticipated loss, and risk of loss on part of insured is occasioned by some future or contingent event, and is shifted to or assumed by insurer, and there is also a distribution of risk of loss by payment of a premium or other assessment into a general fund which permits insurer to accept each risk at a small fraction of possible liability upon it. Metropoli-

tan Police Retiring Ass'n v. Tobriner, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

Subchapter II. Powers and Duties of the Commissioner.

§ 31-2502.01. Records of Commissioner; rules and regulations.

(a) The office of the Commissioner shall be a public office, and the records, books, and papers thereof on file therein shall be public records of the District, except as the Commissioner for good reason may decide otherwise, or except as it may be provided otherwise herein.

(b) The Commissioner may, in accordance with § 2-505, promulgate reasonable rules and regulations as are necessary to implement the provisions of this chapter.

(Oct. 9, 1940, 54 Stat. 1066, ch. 792, ch. II, § 1; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; Apr. 5, 2005, D.C. Law 15-292, § 2, 52 DCR 1463; Mar. 2, 2007, D.C. Law 16-191, § 53, 53 DCR 6794.)

Prior Codifications. — 1981 Ed., § 35-1504.

1973 Ed., § 35-1304.

Effect of amendments. — D.C. Law 15-292 rewrote subsec. (b) which had read:

“(b) The Council of the District of Columbia shall have authority to make, and the Commissioner shall have the authority to enforce, such reasonable rules and regulations as may be necessary in making effective the provisions of this chapter, but such rules and regulations shall not be contrary to nor inconsistent with the provisions of this chapter.”

D.C. Law 16-191, in subsec. (b), validated a previously made technical correction.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 15-292. — Law 15-292, the “Fire and Casualty Amendment Act of 2004”, was introduced in Council and assigned Bill No. 15-878, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 9, 2004, and December 7, 2004, respectively. Signed by the Mayor on December 29, 2004, it was assigned Act No. 15-688 and transmitted to both Houses of Congress for its review. D.C. Law 15-292 became effective on April 5, 2005.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 402(277) of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to the District of Columbia Council, subject to the right of the Commissioner as provided in § 406 of the Plan. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-2502.02. Certificate of authority to do business — Issuance or renewal.

(a) The Commissioner shall issue a certificate of authority to a company

when it shall have complied with the requirements of the laws of the District so as to be entitled to do business therein. The Commissioner may, however, satisfy himself by such investigation as he may consider proper or necessary that the company is duly qualified under the laws of the District to transact business therein, and may refuse to issue or renew the certificate to a company if the issuance or renewal of the certificate would adversely affect the public interest. In each case, the certificate shall be issued under the seal of the Commissioner authorizing and empowering the company to transact the kind of business specified in the certificate, and the certificate shall expire on the 30th day of April next succeeding the date of its issuance.

(b) Repealed.

(c) No company shall transact any business in or from the District until it shall have received a certificate of authority as authorized by this section, and no company shall transact any business not specified in the certificate of authority. No domestic mutual company shall transact any business in the District until it has bona fide applications for insurance covering not less than 200 separate risks in not less than 20 policies to be issued to not less than 20 members, and has received the cash premium therefor, and has a surplus of not less than the amount provided under §§ 31-2502.12 and 31-2502.13.

(Oct. 9, 1940, 54 Stat. 1066, ch. 792, ch. II, § 2; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-190, § 3(a), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 603(a), 49 DCR 6968; Mar. 8, 2007, D.C. Law 16-232, § 202(a), 54 DCR 368.)

Cross references. — Authority of Council to regulate, modify, or eliminate license requirements and to promulgate regulations, see §§ 47-2842, 47-2844.

Issuance of certificate, see § 31-2502.15.

Section references. — This section is referred to in §§ 31-301, 31-1501, 31-2501.03, 31-2502.15, and 31-250

Prior Codifications. — 1981 Ed., § 35-1505.

1973 Ed., § 35-1305.

Effect of amendments. — D.C. Law 13-190 inserted after the third sentence the new fourth and fifth sentences.

D.C. Law 14-190 rewrote the section which had read as follows: "It shall be the duty of the Commissioner to issue a certificate of authority to a company when it shall have complied with the requirements of the laws of the District so as to be entitled to do business therein. The Commissioner may, however, satisfy himself by such investigation as he may deem proper or necessary that such company is duly qualified under the laws of the District to transact business therein, and may refuse to issue or renew any such certificate to a company if the issuance or renewal of such certificate would adversely affect the public interest. In each case the certificate shall be issued under the seal of the Commissioner authorizing and empowering

the company to transact the kind or kinds of business specified in the certificate, and each such certificate shall be made to expire on the 30th day of April next succeeding the date of its issuance. A company may, at its own option and expense, submit a statement from an independent organization acceptable to the Commissioner, attesting that it meets all the requirements of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority. The statement shall be signed, under oath, by an officer or principal of the independent organization and shall be considered prima facie evidence by the Commissioner that the company is entitled to do business in the District, subject to (1) an investigation and review, and (2) the Commissioner's authority to revoke or suspend a certificate of authority as provided in this chapter. No company shall transact any business in or from the District until it shall have received a certificate of authority as authorized by this section, and no company shall transact any business not specified in such certificate of authority. No domestic mutual company shall transact any business in the District until it has bona fide applications for insurance covering not less than 200 separate risks in not less than 20 policies to be issued to not less than 20 members, and has received the

cash premium therefor, and has a surplus of not less than the amount provided under §§ 31-2502.12 and 31-2502.13.”

D.C. Law 16-232 repealed (b), which formerly read: “(b) the Commissioner may, in accordance with § 2-505, promulgate reasonable rules and regulations as are necessary to implement the provisions of this chapter.”

Emergency legislation. — For temporary (90 day) amendment of section, see § 603(a) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 13-190. — Law 13-190, the “Insurer and Health Maintenance Organization Self-Certification Act of 2000,” was introduced in Council and assigned Bill No. 13-722, which was referred to the Committee on Consumer and Regulatory Affairs. The

Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 2, 2000, it was assigned Act No. 13-407 and transmitted to both Houses of Congress for its review. D.C. Law 13-190 became effective on October 21, 2000.

Legislative history of Law 14-190. — Law 14-190, the “Fiscal Year 2003 Budget Support Act of 2002,” was introduced in Council and assigned Bill No. 14-609, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 7, 2002, and June 4, 2002, respectively. Signed by the Mayor on July 3, 2002, it was assigned Act No. 14-403 and transmitted to both Houses of Congress for its review. D.C. Law 14-190 became effective on October 1, 2002.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

CASE NOTES

ANALYSIS

Construction and application.

Location.

Multiple certificates.

Construction and application.

The 1940 Act requiring that all fire, marine and casualty companies doing business in District of Columbia must obtain certificate of authority expressly repealed earlier statute exempting nonprofit relief associations composed of government employees from licensing and regulation, and consequently unincorporated nonprofit labor organization composed exclusively of postal clerks employed by United States Post Office Department must obtain from superintendent of insurance certificate of authority to operate program of health insurance. D.C. Code 1951, §§ 11-776(b), 35-202, 35-1301 et seq., 35-1302, 35-1303, 35-1349 note. *National Federation of Post Office Clerks v. District of Columbia*, 173 A.2d 483, 1961 D.C. App. LEXIS 270 (Cr.App. 1961).

Location.

District of Columbia regulation generally precluding the insurance company from considering geographic location in determining whether to insure or continue to insure auto, fire and casualty risks in district and prohibiting cancellation of those policies for other than specified conditions do not conflict with specific

provisions of the District of Columbia Insurance Code or the Automobile Insurance Plan and were not preempted thereby; with respect to basic property insurance regulation prohibiting geographic discrimination did conflict with and was preempted by the District of Columbia Insurance Placement Act. D.C. Code §§ 1-226, 35-1503(c), 35-1505, 35-1505(d), 35-1701 et seq.; *National Housing Act*, § 1201, 12 U.S.C. § 1749bbb. *Firemen’s Ins. Co. v. Washington*, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

Multiple certificates.

Insurer who seeks licenses under the Life Insurance Act and the Fire and Casualty Act bears responsibility of satisfying the more stringent requirement regardless of which statute prescribes it, and if two certificates are issued, each must stand on its own feet. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

Life Insurance Act of District of Columbia and Fire and Casualty Act do not prohibit issuance of certificate or certificates authorizing a single insurer to do both life and casualty insurance business. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

**§ 31-2502.03. Certificate of authority to do business —
Revocation or suspension.**

(a) The Commissioner shall have power to revoke or suspend the certificate of authority to transact business in the District of any company which has failed or refused to comply with any provision or requirement of this chapter, or which:

(1) Is impaired in capital or surplus;

(2) Is insolvent;

(3) Is determined, pursuant to Chapter 21 of this title, to be in such condition that further transaction of business by the company will be hazardous to its policyholders, creditors, or the general public;

(4) Has refused or neglected to pay a valid final judgment against such company within 30 days after such judgment shall have become final either by expiration without appeal within the time when such appeal might have been perfected, or by final affirmance on appeal;

(5) Has violated any law of the District or has in the District violated its charter or exceeded its corporate powers;

(6) Has refused to submit its books, papers, accounts, records, or affairs to the reasonable inspection or examination of the Commissioner, his deputies, or duly appointed examiners;

(7) Has an officer who has refused upon reasonable demand to be examined under oath touching its affairs;

(8) Fails to file with the Commissioner a copy of an amendment to its charter or articles of association within 30 days after the effective date of such amendment;

(9) Has had its corporate existence dissolved or its certificate of authority revoked in the state in which it was organized;

(10) Has had all its risks reinsured in their entirety in another company, without prior approval of the Commissioner;

(11) Has made, issued, circulated, or caused to be issued or circulated any estimate, illustration, circular, or statement of any sort misrepresenting either its status or the terms of any policy issued or to be issued by it, or the benefits or advantages promised thereby, or the dividends or shares of the surplus to be received thereon, or has used any name or title of any policy or class of policies misrepresenting the true nature thereof;

(12) Has filed, caused to be filed, or failed to prevent the filing of, a statement on its behalf from an independent organization attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information; or

(13) Has filed, caused to be filed, or failed to prevent the filing of a statement on its behalf from a corporate officer attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information.

(b) The Commissioner shall not revoke or suspend the certificate of authority of any company until he has given the company not less than 30 days notice

of the proposed revocation or suspension and of the grounds alleged therefor, and has afforded the company an opportunity for a full hearing; provided, that if the Commissioner shall find upon examination that the further transaction of business by the company would be hazardous to the public or to the policyholders or creditors of the company in the District, he may suspend such authority without giving notice as herein required; provided further, that in lieu of revoking or suspending the certificate of authority of any company for causes enumerated in this section after hearing as herein provided, the Commissioner may subject such company to a penalty of not more than \$10,000 for any violation, or not more than \$25,000 for intentional violations, when in his judgment he finds that public interest would be best served by the continued operation of the company. The amount of any such penalty shall be paid by the company through the office of the Commissioner to the Collector of Taxes, District of Columbia. At any hearing provided by this section, the Commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely after having been administered such an oath shall be subject to the penalties of perjury. Civil fines, penalties, and fees may be imposed as alternative sanctions for any infraction of the provisions of this chapter, or any rules or regulations issued under the authority of this chapter, pursuant to Chapter 18 of Title 2. Adjudication of any infraction of this chapter shall be pursuant to Chapter 18 of Title 2.

(Oct. 9, 1940, 54 Stat. 1066, ch. 792, ch. II, § 3; Apr. 22, 1944, 58 Stat. 192, ch. 173, § 1; Feb. 22, 1958, 72 Stat. 21, Pub. L. 85-334, § 4; Mar. 14, 1985, D.C. Law 5-160, § 2(a), 32 DCR 39; Oct. 5, 1985, D.C. Law 6-42, § 447(a), 32 DCR 4450; Mar. 8, 1991, D.C. Law 8-237, § 2(r)(1), 38 DCR 314; Apr. 26, 1994, D.C. Law 10-103, § 7(b), 41 DCR 1005; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-190, § 3(b), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 603(b), 49 DCR 6968; Mar. 13, 2004, D.C. Law 15-105, § 65, 51 DCR 881.)

Cross references. — Administrative procedure, see § 2-501 et seq.

Annual audited financial reports, qualified independent certified public accountants, proceedings to determine qualification, see § 31-305.

Credit life, accident, and health insurance violations, proceedings, see § 31-5111.

Examinations, violations, conduct of proceedings, see § 31-1403.

General penalties for violation of insurance laws, see § 31-2502.42.

Regulation of casualty and other insurance rates, violations, see § 31-2709.

Violation of provisions applicable to more than one kind of insurance, suspension or revocation of license or certificate, see § 31-1608.

Prior Codifications. — 1981 Ed., § 35-1506.

1973 Ed., § 35-1306.

Effect of amendments. — D.C. Law 13-190 added par. (12) to subsec. (a).

D.C. Law 14-190, in subsec. (a), made nonsubstantive changes to pars. (11) and (12), and added par. (13).

D.C. Law 15-105, in par. (12) of subsec. (a), validated a previously made technical correction.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Emergency legislation. — For temporary (90 day) amendment of section, see § 603(b) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 5-160. — Law 5-160, the "Life Insurance Amendments Reform Act of 1984," was introduced in Council and assigned Bill No. 5-471, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and

second readings on November 20, 1984, and December 4, 1984, respectively. Signed by the Mayor on December 7, 1984, it was assigned Act No. 5-225 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-42. — Law 6-42, the "Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985," was introduced in Council and assigned Bill No. 6-187, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 25, 1985, and July 9, 1985, respectively. Signed by the Mayor on July 16, 1985, it was assigned Act No. 6-60 and transmitted to both Houses of Congress for its review.

Legislative history of Law 8-237. — Law 8-237, the "Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985 Technical and Clarifying Amendments Act of 1990," was introduced in Council and assigned Bill No. 8-203, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 4, 1990, and December 18, 1990, respectively. Signed by the Mayor on December 27, 1990, it was assigned Act No. 8-320 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and February 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 13-190. — For Law 13-190, see notes following § 31-2501.03.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 15-105. — For Law 15-105, see notes following § 31-2402.

Editor's notes. — Office of Collector of Taxes abolished: The Office of the Collector of Taxes was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Collector of Taxes including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3, dated August 28, 1952. Reorganization Order No. 20, dated November 10, 1952, transferred the functions of the Collector of Taxes to the Finance Office. The same Order provided for the Office of the Collector of Taxes headed by a Collector in the Finance Office, and abolished the previously existing Office of the Collector of Taxes. Reorganization Order No. 20 was superseded and replaced by Organization Order No. 121, dated December 12, 1957, which provided that the Finance Office (consisting of the Office of the Finance Officer, Property Tax Division, Revenue Division, Treasury Division, Accounting Division, and Data Processing Division) would continue under the direction and control of the Director of General Administration, and that the Treasury Division would perform the function of collecting revenues of the District of Columbia and depositing the same with the Treasurer of the United States. Organization Order No. 121, was revoked by Organization Order No. 3, dated December 13, 1967, Part IVC of which prescribed the functions of the Finance Office within a newly established Department of General Administration. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Functions of the Finance Office as stated in Part IVC of Organization Order No. 3 were transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969. The collection functions of the Director of the Department of Finance and Revenue were transferred to the District of Columbia Treasurer by § 47-316 on March 5, 1981.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

CASE NOTES

Nonrenewal of certificates.

Where evidence amply supported finding that policy-writing agent for insurance company violated insurance laws by failing to furnish policies or comparable evidence of insurance to which insured persons were entitled and that agent represented that it had author-

ity to solicit and procure policies of insurance when it had no license to do so, refusal of Superintendent of Insurance to renew agent's license was proper. D.C. Code 1940, §§ 35-1336, 35-1339, 35-1340, 35-1507(d). *Columbia Auto Loan v. Jordan*, 196 F.2d 568, 1952 U.S. App. LEXIS 2496 (C.A.D.C. 1952).

§ 31-2502.04. Cessation of business.

If a company shall cease to do business in the District, it shall thereupon make report to the Commissioner of the taxable premiums collected which have not been reported prior to the date of the cessation of business, and shall forthwith pay to the Collector of Taxes of the District, through the Commissioner, a tax thereon computed according to law. If a company fails or refuses to make such a report or to pay the tax imposed upon it as required by law, it shall be liable to the District for the amount of such taxes, plus a penalty of 8 per centum per month for each month or part thereof during which such taxes remain unpaid.

(Oct. 9, 1940, 54 Stat. 1067, ch. 792, ch. II, § 4; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Cross references. — Exemption of marine insurance from operation of general tax laws, see § 47-2608.

Prior Codifications. — 1981 Ed., § 35-1507.

1973 Ed., § 35-1307.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

Office of Collector of Taxes abolished: See Historical and Statutory Notes following § 31-2502.03.

§ 31-2502.05. Receivership proceedings. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-35, § 59(b), 40 DCR 5773.)

Prior Codifications. — 1981 Ed., §§ 35-1508 to 35-1510.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-35. — Law 10-35, "Insurers Rehabilitation and Liquidation Act of 1993," was introduced in Council and assigned Bill No. 10-123, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-68 and transmitted to both Houses of Congress for its review. D.C. Law 10-35 became effective on October 15, 1993.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-2502.03.

Editor's notes. — D.C. Law 10-76 and D.C. Law 10-103 purported to amend former § 35-1508 1981 Ed. by rewriting (a)(1)(D).

D.C. Law 10-103, § 7(b) (41 DCR 1005), eff. April 26, 1994, subsequent to its repeal, amended former § 35-1508(a)(1)(D) 1981 Ed. to read:

"(D) Is determined, pursuant to the Standards to Identify Insurance Companies Deemed to be in Hazardous Financial Condition Act of 1993, to be in such condition that further transaction of business by the company will be hazardous to its policyholders, creditors, or the general public;"

§ 31-2502.06. Receivership proceedings; insolvency; impairment. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-35, § 59(b), 40 DCR 5773.)

Prior Codifications. — 1981 Ed., §§ 35-1508 to 35-1510.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-35. — Law 10-35, “Insurers Rehabilitation and Liquidation Act of 1993,” was introduced in Council and assigned Bill No. 10-123, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-68 and transmitted to both Houses of Congress for its review. D.C. Law 10-35 became effective on October 15, 1993.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-2502.03.

Editor’s notes. — D.C. Law 10-76 and D.C. Law 10-103 purported to amend former § 35-1508 [1981 Ed.] by rewriting (a)(1)(D).

D.C. Law 10-103, § 7(b) (41 DCR 1005), eff. April 26, 1994, subsequent to its repeal, amended former § 35-1508(a)(1)(D) [1981 Ed.] to read:

“(D) Is determined, pursuant to the Standards to Identify Insurance Companies Deemed to be in Hazardous Financial Condition Act of 1993, to be in such condition that further transaction of business by the company will be hazardous to its policyholders, creditors, or the general public;”

§ 31-2502.07. Receivership proceedings; insolvency; impairment. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-35, § 59(b), 40 DCR 5773.)

Prior Codifications. — 1981 Ed., §§ 35-1508 to 35-1510.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-35. — Law 10-35, “Insurers Rehabilitation and Liquidation Act of 1993,” was introduced in Council and assigned Bill No. 10-123, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-68 and transmitted to both Houses of Congress for its review. D.C. Law 10-35 became effective on October 15, 1993.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-2502.03.

Editor’s notes. — D.C. Law 10-76 and D.C. Law 10-103 purported to amend former § 35-1508 [1981 Ed.] by rewriting (a)(1)(D).

D.C. Law 10-103, § 7(b) (41 DCR 1005), eff. April 26, 1994, subsequent to its repeal, amended former § 35-1508(a)(1)(D) [1981 Ed.] to read:

“(D) Is determined, pursuant to the Standards to Identify Insurance Companies Deemed to be in Hazardous Financial Condition Act of 1993, to be in such condition that further transaction of business by the company will be hazardous to its policyholders, creditors, or the general public;”

§ 31-2502.08. Required annual financial statements. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-42, § 7(c), 40 DCR 6020.)

Prior Codifications. — 1981 Ed., § 35-1511.

Legislative history of Law 10-42. — Law 10-42, the “Required Annual Financial Statements and Participation in the NAIC Insurance Regulatory Information System Act of 1993,”

was introduced in Council and assigned Bill No. 10-129, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993,

it was assigned Act No. 10-77 and transmitted to both Houses of Congress for its review. D.C. Law 10-42 became effective on October 21, 1993.

§ 31-2502.09. Making or publishing material false statements.

Any director, officer, agent, or employee of any company who subscribes to, makes or concurs in making or publishing any annual or other statement required by law, knowing the same to contain any material statement which is false, shall be fined not more than \$5,000 or imprisoned for not more than 5 years, or both.

(Oct. 9, 1940, 54 Stat. 1069, ch. 792, ch. II, § 9.)

Prior Codifications. — 1981 Ed., § 35-1512. 1973 Ed., § 35-1312.

§ 31-2502.10. Examinations by Superintendent; violations; acceptance of reports in lieu of examinations. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-49, § 9(c), 40 DCR 6110.)

Prior Codifications. — 1981 Ed., § 35-1513.

Legislative history of Law 10-49. — Law 10-49, the “Law on Examinations Act of 1993,” was introduced in Council and assigned Bill No. 10-131, which was referred to the Committee on Consumer and Regulatory Affairs. The

Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, and it was assigned Act No. 10-94 and transmitted to both Houses of Congress for its review. D.C. Law 10-49 became effective on October 21, 1993.

§ 31-2502.11. Kinds of insurance authorized.

Any company authorized to do business in the District may, when empowered by its charter, make all or any 1 or more of the kinds of insurance and reinsurance comprised in either or both of the following classes, subject to and in accordance with the provisions of this chapter:

(1) *Fire and marine.* — On houses, buildings, and all other kinds of property against loss, damage, or damages by fire, lightning, or storm; to insure against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers or water pipes; and to make all kinds of insurance against loss of or damage to goods, merchandise, or other property caused by fire, risks of transportation, or navigation, the action of the elements or adverse manifestations of nature, as well as all and every risk or peril to which the subject of insurance may be exposed, against which it is not contrary to public policy to insure, including every insurable interest therein or in the use thereof, or profit or income therefrom, or legal liability therefor, but not to include injury to the person nor loss caused by breach of trust; and

(2) *Casualty.* —

(A) Upon the health of persons, or against injury, disablement, or death

of persons resulting from traveling or general accidents by land or water, and against liability of the assured for injuries to employees or other persons;

(B) Against liability of the assured for loss or destruction of or damage to property;

(C) Upon the lives of domestic animals;

(D) Against loss of or damage to glass and its appurtenances;

(E) Against loss of or damage to any property resulting from the explosion of or injury to any boiler, heater, unfired pressure vessel, pipes, or containers connected therewith, any engine, turbine, compressor, pump, or wheel or any apparatus generating, transmitting or using electricity, or any other machine or apparatus connected with or operated by any of the previously named boilers, vessels, or machines; and including the incidental power to make inspections of and to issue certificates of inspection upon, any such boilers, apparatus, and machinery, whether insured or otherwise;

(F) Against loss by burglary or theft, or both, and against loss of or damage to moneys and securities;

(G) To guarantee and indemnify merchants, traders, and those engaged in business and giving credit, from loss and damage by reason of giving and extending credit to their customers and those dealing with them;

(H) Against loss or damage by water or other fluid or substance to any property resulting from the breakage or leakage of sprinklers or water pipes; and

(I) To insure against any other casualty risk which may lawfully be the subject of insurance, and which it is not contrary to public policy to insure; provided, that this section shall not be construed as having any effect whatever upon the right or authority of any solvent company to make contracts of fidelity or surety.

(Oct. 9, 1940, 54 Stat. 1069, ch. 792, ch. II, § 11; Mar. 24, 1998, D.C. Law 12-81, § 29(a), 45 DCR 745.)

Cross references. — Employees' Compensation Act, insurance under, see § 31-5205.

Prohibition against wagering policies, see § 31-2601.01.

Prior Codifications. — 1981 Ed., § 35-1514.

1973 Ed., § 35-1314.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998,"

was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1998, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

§ 31-2502.12. Limitations on exposure to risks or hazards.

No company other than a mutual or reciprocal company doing business in the District shall expose itself to any loss on any one risk or hazard, whether located in the District or outside of the District, to an amount exceeding 10% of the sum of its capital stock and surplus. No mutual or reciprocal company shall expose itself to any loss on any one risk or hazard, whether located in the District or outside of the District, to an amount exceeding 10% of its surplus. No portion of any such risk or hazard which shall have been reinsured in a company authorized to do business in the District shall be included in

determining limitation of risk; provided, that the provisions of this section shall not apply to the insurance of workmen's compensation, employers' liability, marine, or inland marine risks.

(Oct. 9, 1940, 54 Stat. 1070, ch. 792, ch. II, § 12; Apr. 26, 1994, D.C. Law 10-103, § 3, 41 DCR 1005; Mar. 8, 2007, D.C. Law 16-232, § 202(b), 54 DCR 368.)

Cross references. — Capital and surplus requirements for foreign and alien companies, see § 31-2502.22.

Limitation of risk for companies operating on Lloyd's plan, see § 31-2502.20a.

Section references. — This section is referred to in § 31-2502.02.

Prior Codifications. — 1981 Ed., § 35-1515.

1973 Ed., § 35-1315.

Effect of amendments. — D.C. Law 16-232 substituted "any one risk or hazard, whether located in the District or outside of the District" for "any 1 risk or hazard in the District".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3 of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-2502.03.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.13. Minimum capital and surplus requirements.

Every stock company authorized to do business in the District shall have and shall at all times maintain a paid-up capital stock of not less than \$300,000, and a surplus of not less than \$300,000. Every domestic mutual company and every domestic reciprocal company shall have and shall at all times maintain a surplus of not less than \$300,000 and every foreign or alien mutual company and every foreign or alien reciprocal company shall have and shall at all times maintain a surplus of not less than \$400,000.

(Oct. 9, 1940, 54 Stat. 1070, ch. 792, ch. II, § 13; Apr. 16, 1966, 80 Stat. 121, Pub. L. 89-399, § 1(b); Aug. 14, 1973, 87 Stat. 304, Pub. L. 93-89, title IV, § 401.)

Cross references. — Independent certified public accountant, report demonstrating minimum capital and surplus requirement, see § 31-308.

Security, guarantee, indemnity, loan, and mortgage business, capital stock, see § 26-1301.

Surplus required for operation under Lloyd's plan, see § 31-2502.20a.

Section references. — This section is referred to in § 31-2502.02.

Prior Codifications. — 1981 Ed., § 35-1516.

1973 Ed., § 35-1316.

§ 31-2502.14. Applicability of provisions to existing companies.

No company shall be exempt from the provisions of this chapter by reason of its having been incorporated in the District or elsewhere prior to the effective date of this chapter, except that, in the case of companies authorized in the District on October 9, 1940, and continuously thereafter without any increase of authority, the minimum capital and surplus required of a stock company, and the minimum surplus required of a mutual or reciprocal company, or of a

Lloyd's organization, by the laws of the District heretofore applicable shall not be increased by this chapter, and provided also that in the case of such continuously authorized companies the provisions of § 31-2502.24 relating to the names of companies, and the provisions of § 31-2502.25 relating to the amount of surplus necessary to the issuance of policies having no provision for contingent liability, shall not be applicable.

(Oct. 9, 1940, 54 Stat. 1070, ch. 792, ch. II, § 14; Aug. 14, 1973, 87 Stat. 304, Pub. L. 93-89, title IV, § 401; Feb. 23, 1980, D.C. Law 3-52, § 4, 27 DCR 26.)

Section references. — This section is referred to in §§ 31-2502.24 and 31-2502.25.

Prior Codifications. — 1981 Ed., § 35-1517.

1973 Ed., § 35-1317.

Legislative history of Law 3-52. — Law 3-52, the "District of Columbia Insurance Act Amendment of 1979," was introduced in Council and assigned Bill No. 3-53, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first

and second readings on November 20, 1979, and December 4, 1979, respectively. Signed by the Mayor on December 21, 1979, it was assigned Act No. 3-142 and transmitted to both Houses of Congress for its review.

References in text. — "The effective date of this chapter," referred to near the beginning of the section, means the effective date of the Act of October 9, 1940. Section 48 of such Act provided that the Act would become effective 30 days after October 9, 1940.

§ 31-2502.15. Formation of domestic companies.

Any domestic stock, mutual, or reciprocal company desiring to transact business in the District shall, after complying with the general laws of the District governing the formation of companies or corporations, file with the Commissioner copies of its articles of incorporation, bylaws, charter, proposed forms of policies, and such other information as may be necessary to manifest and explain the organization, objects, and purposes of the company, and to satisfy the Commissioner that such company has complied with the laws of the District regarding the formation of companies. Thereafter, upon application made to the Commissioner upon such forms as the Commissioner shall prescribe, the Commissioner, subject to the provisions of § 31-2502.02, shall issue to the company a certificate of authority to transact business in the District.

(Oct. 9, 1940, 54 Stat. 1071, ch. 792, ch. II, § 15; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1518.

1973 Ed., § 35-1318.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.16. Acquisition, use and disposition of real estate by domestic companies. [Repealed].

Repealed.

(Oct. 9, 1940, 54 Stat. 1071, ch. 792, ch. II, § 16; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 29(b), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(a), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1519.

1973 Ed., § 35-1319.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 12-81. — For

legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2502.11.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.17. Power of domestic mutual companies to borrow or assume liability.

A domestic mutual company may borrow or assume liability for the repayment of a sum of money sufficient to defray the reasonable expenses of its organization or to enable it to comply with any requirement of law or as a surplus fund upon agreement which shall first be submitted to and approved by the Commissioner that such loan or advance with interest at a rate not exceeding 6% per annum shall be repaid only with the approval of the Commissioner whenever in his judgment the company shall be in possession of sufficient surplus in excess of a surplus equal to the amount required by this chapter. Any such loan or advance shall not form a part of the legal liabilities of the company, but until such loan or advance has been repaid all statements published by such company or filed with the Commissioner shall show the amount thereof then remaining unpaid.

(Oct. 9, 1940, 54 Stat. 1071, ch. 792, ch. II, § 17; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1520.

1973 Ed., § 35-1320.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.18. Investment of funds by domestic companies. [Repealed].

Repealed.

(Oct. 9, 1940, 54 Stat. 1072, ch. 792, ch. II, § 18; July 19, 1954, 68 Stat. 494, ch. 546, § 1; Oct. 3, 1962, 76 Stat. 715, Pub. L. 87-739, § 2; Oct. 30, 1981, D.C. Law 4-50, § 3, 28 DCR 4258; Mar. 9, 1983, D.C. Law 4-174, § 3, 29 DCR 5753; June 13, 1990, D.C. Law 8-141, § 3, 37 DCR 2654; Apr. 11, 2003, D.C. Law 14-297, § 401(a), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1521.

1973 Ed., § 35-1321.

Legislative history of Law 4-50. — Law 4-50, the "District of Columbia Local Business Investment Act of 1981," was introduced in Council and assigned Bill No. 4-137, which was referred to the Committee on Housing and Economic Development. The Bill was adopted

on first and second readings on July 14, 1981, and July 28, 1981, respectively. Signed by the Mayor on August 6, 1981, it was assigned Act No. 4-77 and transmitted to both Houses of Congress for its review.

Legislative history of Law 4-174. — Law 4-174, the "Eviction Limitation, Fire and Casualty Amendment Act, and Anti-Drunk Driving Clarifying Amendments Act of 1982," was intro-

duced in Council and assigned Bill No. 4-398, which was referred to the Committee on Housing and Economic Development. The Bill was adopted on first and second readings on October 19, 1982, and November 16, 1982, respectively. Signed by the Mayor on December 8, 1982, it was assigned Act No. 4-257 and transmitted to both Houses of Congress for its review.

Legislative history of Law 8-141. — Law 8-141, the “African Development Bank and Asian Development Bank Investment Amendment Act of 1990,” was introduced in Council and assigned Bill No. 8-127, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on March 13, 1990, and March 27, 1990, respectively. Signed by the Mayor on April 17, 1990, it was assigned Act No. 8-197 and transmitted to both Houses of Congress for its review.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor’s notes. — Home Owners’ Loan Corporation abolished: The Home Owners’ Loan Corporation, referred to in paragraph (9) of subsection (a), was dissolved by order of the Secretary of the Home Loan Bank Board, effective February 3, 1954, pursuant to the Act of June 30, 1953, 67 Stat. 121.

§ 31-2502.19. Exclusive agency contracts of domestic companies.

No domestic company authorized to do an insurance business in the District shall have or make any contract with any person whereby such person is granted the exclusive right or privilege to solicit, procure, write, produce, or manage the entire insurance business of such company, or to collect premiums therefor, unless such contract is filed with and approved in writing by the Commissioner. The Commissioner shall not approve any such contract which:

(1) Subjects the company to excessive charges for expenses or commissions; or

(2) Gives to such person the right to manage any of the affairs of such company or the exclusive right to solicit, procure, write, or produce the entire insurance business for such company, or to collect the premiums therefor for such unreasonable period as may jeopardize the interests or security of the company’s policyholders.

(Oct. 9, 1940, 54 Stat. 1073, ch. 792, ch. II, § 19; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1522.

1973 Ed., § 35-1322.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.20. Authority to transact business — Foreign or alien companies.

Upon complying with the provisions of this chapter, a foreign or alien company organized as a stock, mutual, or reciprocal company, or as a Lloyd’s organization, but not otherwise, may be authorized by certificate of authority to transact in the District the kind or kinds of business which a domestic company similarly organized may be authorized to transact under this chapter. Such certificate of authority shall be issued as provided under § 31-2502.02. The issuance of a certificate of authority to a Lloyd’s organization shall be subject to the provisions of § 31-2502.20a. Any company chartered by special

act of the legislature of its state of domicile prior to the effective date of this chapter, as provided in § 48 of this act, as a company without capital stock but doing business exclusively on the stock plan and maintaining at all times a surplus of not less than \$300,000 shall, in the administration of this chapter, be considered as a stock company.

(Oct. 9, 1940, 54 Stat. 1073, ch. 792, ch. II, § 20; June 27, 1960, 74 Stat. 222, Pub. L. 85-526, § 1.)

Prior Codifications. — 1981 Ed., § 35-1523.

1973 Ed., § 35-1323.

References in text. — “Section 48 of this

act,” referred to in the last sentence of this section, means § 48 of the Act of October 9, 1940, which provided that such Act would be effective 30 days after October 9, 1940.

CASE NOTES

Multiple certificates.

Insurer who seeks licenses under the Life Insurance Act and the Fire and Casualty Act bears responsibility of satisfying the more stringent requirement regardless of which statute prescribes it, and if two certificates are issued, each must stand on its own feet. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

Life Insurance Act of District of Columbia and Fire and Casualty Act do not prohibit issuance of certificate or certificates authorizing a single insurer to do both life and casualty insurance business. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

§ 31-2502.20a. Authority to transact business — Lloyd's organizations.

Individuals and aggregations of individuals transacting an insurance business upon the plan known as Lloyd's whereby the individual underwriters become liable severally for specified proportions of the whole amount insured by a policy, heretofore organized under the laws of a state of the United States, or of a foreign government, may be authorized to transact business in the District, upon the following conditions:

(1) They shall comply with and be subject to the same terms, conditions, and provisions as are imposed by this chapter upon foreign stock insurance companies, except as provided in the next succeeding paragraph and except that the maximum amount of insurance to be assumed by an individual underwriter upon any single risk for each kind of insurance shall not exceed 10% of the value of the cash and securities deposited in trust by such underwriter, plus the share of admitted assets other than underwriter's deposits of such Lloyd's belonging to such underwriter, less the share of liabilities and reserves of such Lloyd's allocable to such underwriter, but in no event shall it exceed 10 per centum of the value of cash or securities deposited in trust by such underwriter;

(2) They shall have and shall at all times maintain surpluses of not less than \$300,000 in the aggregate and shall at all times have on deposit with an insurance department of a state of the United States, or with a bank or trust company designated by such insurance department, for the benefit of all

policyholders within the United States the sum of at least \$350,000 in cash or in securities such as are required for the investment of the assets of insurance companies authorized to do business in the District: Provided, that they shall not be required to establish or maintain such a deposit if they have on deposit in the hands of a bank or trust company in the United States as trustee cash deposits or securities issued by the United States worth not less than \$2,000,000 in the aggregate and held in trust for the benefit of all policyholders in the United States;

(3) They shall file with the Commissioner an authenticated copy of their powers of attorney and an authenticated copy of the trust agreement, or other agreement under which deposits made by underwriters are held;

(4) They shall notify the Commissioner forthwith of any amendments to their powers of attorney, deposit agreement, or other documents underlying their organization, by filing with the Commissioner an authenticated copy of such document as amended;

(5) They shall notify the Commissioner forthwith of any change in their names or change of attorney-in-fact, or change of address of their attorney-in-fact;

(6) In the case of an alien Lloyd's, their annual statement shall embrace only their condition and transactions in the United States, and may be verified by the oath of their resident manager or other person or persons having proper authority; and

(7) There shall be filed with the Commissioner by the attorney-in-fact at the time of filing the annual statement, or more often if the Commissioner requires, a statement verified by the appropriate official of such Lloyd's, setting forth:

(A) The names and addresses of all the underwriters of such Lloyd's;

(B) A description of the cash and securities deposited in trust by each underwriter;

(C) The maximum amount of insurance assumed by each underwriter upon any single risk or each kind of insurance; and

(D) That the maximum amount of insurance assumed upon any single risk for each kind of insurance by any individual underwriter does not exceed the limitation provided for in paragraph (1) of this section.

(Oct. 9, 1940, 54 Stat. 1073, ch. 792, ch. II, § 20a; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-2502.20.

Prior Codifications. — 1981 Ed., § 35-1524.

1973 Ed., § 35-1324.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.21. Procurement of certificate of authority by foreign or alien companies — Application forms.

A foreign or alien company, in order to procure a certificate of authority to transact business in the District, shall make application therefor to the Commissioner on forms prescribed and furnished by the Commissioner. Such forms shall be executed for the company, by its president or vice-president, or executive officer corresponding thereto, and verified by such officer, and if a corporation the corporate seal shall be thereto affixed, attested by its secretary or other proper officer.

(Oct. 9, 1940, 54 Stat. 1074, ch. 792, ch. II, § 21; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Cross references. — Foreign or alien fraternal benefit society, admission, see § 31-5326.

Prior Codifications. — 1981 Ed., § 35-1525.
1973 Ed., § 35-1325.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.22. Procurement of certificate of authority by foreign or alien companies — Delivery of certain documents to Commissioner; required showings; authorized examinations.

A foreign or alien company shall deliver to the Commissioner: (1) an application of the company for a certificate of authority; (2) a copy of its articles of incorporation or articles of association and amendments thereto, duly certified by the proper officer of the state or country under whose laws the company is organized or incorporated, or if reciprocal, the power of attorney of the attorney-in-fact; (3) if an alien company, a copy of the appointment and authority of its United States manager, certified by a proper officer of the company; (4) a copy of its bylaws and regulations; (5) forms of contracts and policies it proposes to issue in the District, and forms of the applications therefor, if any; (6) proof of compliance with the service of process provisions of § 31-202; (7) a statement of its financial condition and business as of the end of the preceding calendar year, complying as to form and verification with the requirements of this chapter for annual statements, or financial statement as of such later date as the Commissioner may require; (8) a copy of the last report of examination, certified to by an insurance commissioner or other proper supervisory official; and (9) a certificate from the proper official of the state or country wherein it is incorporated or organized, that it is duly incorporated or organized and is authorized to write the kind or kinds of insurance which it proposes to write in the District. Before a certificate of authority to transact business in the District is issued to a foreign or alien company, such company shall satisfy the Commissioner that: (1) the company is duly organized under the laws of the state or country under whose laws it professes to be organized

and is authorized to do the business it is transacting or proposes to transact; (2) its name is not the same as, or so deceptively similar to, the name of any domestic company, or the name of any department of the federal government or existing corporation authorized to transact business in the District as to mislead the public or cause confusion; (3) if a stock company, it has a paid-up capital and surplus at least equal to the capital and surplus required by this chapter or if a mutual company or reciprocal, it has a surplus and provision for contingent liability of policyholders at least equal to the surplus and provision for contingent liability of policyholders required by this chapter; and (4) its funds are invested in accordance with the laws of its domicile, and in securities or property which afford a degree of financial security substantially equal to that required for similar domestic companies. Before issuing a certificate of authority to a foreign or alien company, the Commissioner may cause an examination to be made of the condition and affairs of such company.

(Oct. 9, 1940, 54 Stat. 1074, ch. 792, ch. II, § 22; Mar. 21, 1995, D.C. Law 10-233, § 6, 42 DCR 24; Apr. 18, 1996, D.C. Law 11-110, § 38, 43 DCR 530; Apr. 9, 1997, D.C. Law 11-255, § 39, 44 DCR 1271; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1526.

1973 Ed., § 35-1326.

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of 1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 11-110. — Law 11-110, the “Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed

by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Legislative history of Law 11-255. — Law 11-255, the “Second Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-905, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-519 and transmitted to both Houses of Congress for its review. D.C. Law 11-255 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.23. Service of process upon foreign or alien companies. [Repealed].

Repealed.

(Mar. 21, 1995, D.C. Law 10-233, § 12, 42 DCR 24.)

Prior Codifications. — 1981 Ed., § 35-1527.

Legislative history of Law 10-233. — For

legislative history of D.C. Law 10-233, see Historical and Statutory Notes following § 31-2502.22.

§ 31-2502.24. Names or designations used by mutual companies and reciprocal or interinsurance exchanges.

Except as otherwise provided in § 31-2502.14, no mutual company shall be authorized to transact business in the District unless the name of such company shall include the word “mutual,” and no reciprocal or interinsurance exchange shall be authorized to transact business in the District unless the name or designation under which reciprocal or interinsurance contracts are to be exchanged shall include the words “reciprocal” or “interinsurance exchange,” or be supplemented by the following words immediately below the name or designation under which such contracts are exchanged: “A reciprocal” or “an interinsurance exchange.”

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 24.)

Section references. — This section is referred to in § 31-2502.14. 1973 Ed., § 35-1328.

Prior Codifications. — 1981 Ed., § 35-1528.

§ 31-2502.25. Premiums of mutual companies.

The maximum premium shall be expressed in the policy of a mutual company, and it may be solely a cash premium, or may be a cash premium and an additional contingent premium, which contingent premium shall be not less than the cash premium, but no mutual company, except as otherwise provided in § 31-2502.14, shall issue any policy for a cash premium without an additional contingent premium until and unless it possesses a surplus of not less than \$600,000.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 25; Aug. 14, 1973, 87 Stat. 305, Pub. L. 93-89, title IV, § 401.)

Section references. — This section is referred to in § 31-2502.14. 1973 Ed., § 35-1329.

Prior Codifications. — 1981 Ed., § 35-1529.

§ 31-2502.26. Company reserves. [Repealed].

Repealed.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 26; Apr. 11, 2003, D.C. Law 14-297, 401(a), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1530.
1973 Ed., § 35-1330.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2502.26a. Actuarial opinion of reserves.

(a) Every property and casualty insurance company doing business in the

District, unless otherwise exempted by the Commissioner, shall annually submit the opinion of an actuary appointed by the company entitled "Statement of Actuarial Opinion." The opinion shall be prepared and filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions.

(b)(1) Every property and casualty insurance company domiciled in the District that is required to submit a Statement of Actuarial Opinion shall annually submit a summary entitled "Actuarial Opinion Summary," written by the actuary appointed by the company. The Actuarial Opinion Summary shall be prepared and filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be a document supporting the Statement of Actuarial Opinion required by subsection (a) of this section.

(2) A company licensed but not domiciled in the District shall provide the Actuarial Opinion Summary upon request.

(c)(1) A report entitled "Actuarial Report" and underlying workpapers as required by the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions shall be prepared to support each Statement of Actuarial Opinion.

(2) If the company fails to provide a supporting Actuarial Report or workpapers at the request of the Commissioner or the Commissioner determines that the supporting Actuarial Report or workpapers provided by the company have been improperly prepared or are otherwise unacceptable, the Commissioner may engage a qualified actuary at the expense of the company to review the Statement of Actuarial Opinion and the basis for the opinion and prepare the supporting Actuarial Report or workpapers.

(d) The actuary appointed by the company shall not be liable for damages to any person other than the insurance company and the Commissioner for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud, willful misconduct, or gross negligence on the part of the actuary.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 26a, as added Mar. 20, 2009, D.C. Law 17-289, § 2, 55 DCR 12619.)

Legislative history of Law 17-289. — Law 17-289, the "Property and Casualty Actuarial Opinion Amendment Act of 2008", was introduced in Council and assigned Bill No. 17-253 which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on Octo-

ber 7, 2008, and November 18, 2008, respectively. Signed by the Mayor on December 8, 2008, it was assigned Act No. 17-576 and transmitted to both Houses of Congress for its review. D.C. Law 17-289 became effective on March 20, 2009.

§ 31-2502.26b. Confidentiality of actuarial opinions, summaries, reports, and workpapers.

(a) The Statement of Actuarial Opinion shall be provided with the annual financial statement required by § 31-1901, in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be a public document.

(b)(1) An Actuarial Report, underlying workpapers, or Actuarial Opinion Summary in the possession or control of the Commissioner, and any other material provided by the company to the Commissioner in connection with the Actuarial Report, workpapers, or Actuarial Opinion Summary, shall not be subject to subchapter II of Chapter 5 of Title 2, except a subpoena issued pursuant to:

(A) A civil action or an administrative proceeding in which insurance premium rates are an issue; or

(B) Oversight by the Council or the federal government.

(2) This section shall not limit the Commissioner's authority to:

(A) Release the documents to the Actuarial Board for Counseling and Discipline if the material is required for the purpose of professional disciplinary proceedings and the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents; or

(B) Use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

(c) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (b) of this section.

(d) To assist in the performance of the Commissioner's duties, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (b) of this section with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the authority to maintain confidentiality;

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) Enter into agreements governing sharing and use of information consistent with subsections (b) through (d) of this section.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (d) of this section.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792; ch. II, § 26b, as added Mar. 20, 2009, D.C. Law 17-289, § 2, 55 DCR 12619.)

Legislative history of Law 17-289. — For Law 17-289, see notes following § 31-2502.26a.

§ 31-2502.27. Filing and approval of policy forms.

The Commissioner may require that all policy forms used by every company covering risks in the District be filed with the Commissioner. The Commissioner shall have authority to disapprove, within 60 days after the date of the receipt of a filing, the use in the District of any policy form which is inequitable, or does not comply with the requirement of the law of the District. If a policy form is not disapproved for use within the 60-day period described above, the Commissioner may not disapprove it for use unless it does not comply with the requirements of the law of the District.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 27; Feb. 27, 1996, D.C. Law 11-90, § 9(b), 42 DCR 7155; Sept. 20, 1996, D.C. Law 11-160, § 3, 43 DCR 3722; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1531.

1973 Ed., § 35-1331.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 9(b) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 10(b) of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 9(b) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 11-90. — For legislative history of D.C. Law 11-90, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 11-160. — Law 11-160, the “Automobile Insurance Amendment Act of 1996,” was introduced in Council and assigned Bill No. 11-157, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on May 7, 1996, and June 4, 1996, respectively. Signed by the Mayor on June 26, 1996, it was assigned Act No. 11-296 and transmitted to both Houses of Congress for its review. D.C. Law 11-160 became effective on September 20, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor’s notes. — Report by Commissioner of Insurance and Securities: Section 5 of D.C. Law 11-160 provided that “Within two years of September 20, 1996, the Commissioner of Insurance and Securities shall prepare and submit to the Council of the District of Columbia for its review a report on the impact of this act on the private passenger motor vehicle insurance market or any part thereof, the funding for the Office of Insurance, the District of Columbia insurance premium tax, the number of insurers doing business in the District, and the number of insurers domiciled in the District of Columbia. In preparing such report, the Commissioner may request from specific private passenger motor vehicle insurers doing business in the District, or from all such insurers, reasonable and pertinent information. Information which is proprietary to any affected insurer shall be treated as confidential by the Commissioner, but may be used in the aggregate with other information from other affected insurers for statistical or other reporting purposes.”

Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

CASE NOTES

ANALYSIS

Approval of policy forms.
 Disapproval of policy forms.
 Duty of superintendent.
 Terms and conditions of policy forms.

Approval of policy forms.

Approval by Superintendent of Insurance of form of proposed endorsement for public liability policies covering taxicabs could not make mandatory inclusion of such endorsement in policies subsequently issued. D.C. Code 1940, § 44-301. *Bennett v. Amalgamated Cas. Ins. Co.*, 200 F.2d 129, 1952 U.S. App. LEXIS 3879 (C.A.D.C. 1952).

Disapproval of policy forms.

The Superintendent of Insurance is required to regulate insurance carriers, to see that they maintain adequate reserves, to scrutinize their costs and fix their rates, all policy forms used by fire, liability and marine insurance companies must be filed with him, and he may disapprove use of any form which is inequitable or which does not comply with requirements of law. D.C. Code 1940, § 35-1331. *Bennett v. Amalgamated Cas. Ins. Co.*, 200 F.2d 129, 1952 U.S. App. LEXIS 3879 (C.A.D.C. 1952).

Duty of superintendent.

The duty of Superintendent of Insurance is to

see that form of taxicab liability policies accurately and equitably meet requirements of Public Utilities Commission. D.C. Code 1940, §§ 35-1331, 44-301. *Bennett v. Amalgamated Cas. Ins. Co.*, 200 F.2d 129, 1952 U.S. App. LEXIS 3879 (C.A.D.C. 1952).

Terms and conditions of policy forms.

Superintendent of Insurance, acting alone, has no power to prescribe the terms and conditions of public liability policies covering taxicabs, since Public Utilities Commission has duty of regulating public liability insurance under statutory provision that taxicab insurance contract shall be in such form and on such terms or conditions as the Commission may direct. D.C. Code 1940, § 44-301. *Bennett v. Amalgamated Cas. Ins. Co.*, 200 F.2d 129, 1952 U.S. App. LEXIS 3879 (C.A.D.C. 1952).

Public Utilities Commission is the only agency authorized to prescribe terms and conditions of taxicab liability policies. D.C. Code 1940, § 44-301. *Bennett v. Amalgamated Cas. Ins. Co.*, 200 F.2d 129, 1952 U.S. App. LEXIS 3879 (C.A.D.C. 1952).

§ 31-2502.28. Rate and form filing requirements for accident and health policies.

The Commissioner may require that the provisions and conditions contained in any policy of insurance against loss or damage from sickness or bodily injury or death of the insured by accident issued by, and the rate-making and filing obligations of, any company authorized by this chapter to transact business in the District be made to conform to the requirements prescribed under § 31-4712.

(Oct. 9, 1940, 54 Stat. 1076, ch. 792, ch. II, § 28; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; Apr. 8, 2011, D.C. Law 18-360, § 501, 58 DCR 896.)

Prior Codifications. — 1981 Ed., § 35-1532.

1973 Ed., § 35-1332.

Effect of amendments. — D.C. Law 18-360, in the section heading, substituted "Rate and form filing requirements for" for "Required provisions in"; and substituted "issued by, and the rate-making and filing obligations of," for "issued by".

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.29. Discriminations prohibited.

Discrimination between individual risks of the same class or hazard in the amount of premiums or rates charged for any policy, or in the benefits or amount of insurance payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited, and the Commissioner is empowered after investigation to order removed at such time and in such manner as he shall specify any such discrimination which his investigation may reveal.

(Oct. 9, 1940, 54 Stat. 1077, ch. 792, ch. II, § 29; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1533.

1973 Ed., § 35-1333.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

§ 31-2502.30. Powers of agents, salaried employees and brokers. [Repealed].

Repealed.

(April 9, 1997, D.C. Law 11-227, § 16(c), 44 DCR 140.)

Prior Codifications. — 1981 Ed., § 35-1534.

Legislative history of Law 11-227. — Law 11-227, the "Insurance Agents and Brokers Licensing Revision Act of 1996," was introduced in Council and assigned Bill No. 11-523, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 1, 1996, and November 7, 1996, respectively. Signed by the Mayor on December 4, 1996, it was as-

signed Act No. 11-455 and transmitted to both Houses of Congress for its review. D.C. Law 11-227 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — D.C. Law 11-268, § 10(r)(2) (44 DCR 1730), eff. May 21, 1997, amends this section subsequent to repeal.

§ 31-2502.31. Compensation of unlicensed persons prohibited.

No company, policy-writing agent, soliciting agent, broker, or salaried employee shall pay any money or commission or brokerage or give or allow any valuable consideration to any person for or because of service in the District in negotiating or effecting a policy on any person, property, business activity, or insurable interest in the District, unless said person is duly licensed in conformity with this chapter as a broker or as an agent or salaried employee of the company issuing the policy. This section shall not apply to contracts of reinsurance, and shall not apply to persons and kinds of insurance exempted under § 31-2502.38.

(Oct. 9, 1940, 54 Stat. 1077, ch. 792, ch. II, § 31.)

Prior Codifications. — 1981 Ed., § 35-1535. 1973 Ed., § 35-1335.

§§ 31-2502.32 to 31-2502.37. Procedure for obtaining licenses; effective dates; temporary transfer of licenses; renewal of licenses; revocation and suspension of licenses; unauthorized solicitation or representation [Repealed].

Repealed.

(April 9, 1997, D.C. Law 11-227, § 16(c), 44 DCR 140.)

Prior Codifications. — 1981 Ed., §§ 35-1536 to 35-1541.

Legislative history of Law 11-227. — For legislative history of D.C. Law 11-227, see Historical and Statutory Notes following § 31-2502.30.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — D.C. Law 11-268, § 10(r)(2) (44 DCR 1730), eff. May 21, 1997, amends former §§ 35-1536, 35-1538, 35-1539, and 35-1540 1981 Ed. subsequent to repeal.

§ 31-2502.38. Exceptions to licensing provisions.

The provisions of this chapter relating to the licensing of policy-writing agents, soliciting agents, salaried company employees, and brokers shall not apply to the sale of personal accident insurance in the ticket offices of railroad companies or other common carriers, or in the offices of travel bureaus, nor to the business of ocean marine insurance, nor to insurance covering the property of railroad companies and other common carriers engaged in interstate commerce.

(Oct. 9, 1940, 54 Stat. 1080, ch. 792, ch. II, § 38; Feb. 22, 1958, 72 Stat. 26, Pub. L. 85-334, § 9.)

Section references. — This section is referred to in § 31-2502.31. 1973 Ed., § 35-1342.

Prior Codifications. — 1981 Ed., § 35-1542.

§ 31-2502.39. Persons not to act for unauthorized companies.

Except as provided in § 31-2502.40, no person shall act as agent in the District for any company which is not authorized to do business in the District, nor shall any person directly or indirectly negotiate for or solicit applications for policies of, or for membership in, any company which is not authorized to do business in the District. The term “company” as used in this section shall include any association, society, company, corporation, joint-stock company, individual, partnership, trustee, or receiver engaged in the business of assuming risks of insurance, surety, or indemnity, and any Lloyd’s organization, assessment, or cooperative fire company, or any reciprocal or interinsurance exchange and any company, association, or society, whether organized for

profit or not, conducting a business, including any of the principles or features of insurance, surety, or indemnity. Any person who violates any provision of this section upon conviction shall be fined not less than \$100 nor more than \$1,000 for each offense, or be imprisoned for not more than 12 months, or both, and any such person shall be personally liable to any resident of the District having claim against any such unauthorized company under any policy which said person has solicited or negotiated, or has aided in soliciting or negotiating; provided, that the provisions of this section shall not apply to any person who negotiates with an unauthorized company for policies covering his own property or interests, nor shall the provisions of this section apply to the officers, agents, or representatives of any company which is in process of organization under the laws of the District, and which is authorized temporarily to solicit or secure memberships or applications for policies for the purpose of completing such organization. Prosecutions for violations of this section shall be upon information filed in the Superior Court of the District of Columbia by the Corporation Counsel or any of his assistants.

(Oct. 9, 1940, 54 Stat. 1080, ch. 792, ch. II, § 39; Feb. 22, 1958, 72 Stat. 26, Pub. L. 85-334, § 10; July 8, 1963, 77 Stat. 77, Pub. L. 88-60, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a).)

Prior Codifications. — 1981 Ed., § 35-1543. 1973 Ed., § 35-1343.

CASE NOTES

ANALYSIS

Defenses.
Evidence.
Injunctions.
Instructions.
Jury questions.

Defenses.

Accused charged with soliciting insurance for company unauthorized to do business in District of Columbia could not defend on ground that company had been granted permits to do business where such permits were not perpetual. D.C. Code 1940, § 35-1342. *Stover v. District of Columbia*, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

Evidence.

In prosecution for soliciting insurance for company unauthorized to do business in District of Columbia, evidence that company once had permit to do business as a fraternal organization was properly excluded as immaterial in view of inclusion of fraternal organizations in statute on which prosecution was based. D.C. Code 1940, § 35-1342. *Stover v. District of Columbia*, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

In prosecution for soliciting insurance for company unauthorized to do business in Dis-

trict of Columbia, evidence which had a direct bearing on solicitation was properly admitted. D.C. Code 1940, § 35-1342. *Stover v. District of Columbia*, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

Injunctions.

The trial judge properly refused to continue prosecution for soliciting insurance business for an unauthorized company, pending trial of suit by company to enjoin officials from interfering with its business. D.C. Code 1940, § 35-1342. *Stover v. District of Columbia*, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

Instructions.

In prosecution for soliciting insurance for company unauthorized to do business in District of Columbia, instruction to acquit if accused did not personally solicit was properly refused, since Congress never intended that liability should be limited to those who personally solicit. D.C. Code 1940, § 35-1342. *Stover v. District of Columbia*, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

Jury questions.

In prosecution for soliciting insurance for company unauthorized to do business in District of Columbia, accused's guilt was for jury. D.C. Code 1940, § 35-1342. *Stover v. District of*

Columbia, 32 A.2d 536, 1942 D.C. App. LEXIS 42 (Cr.App. 1942).

§ 31-2502.40. License to procure policies from unauthorized companies.

(a) Any person may be licensed as a surplus lines insurance producer under Chapter 11A of this title to procure policies from companies which are not authorized to do business in the District where such person is, after diligent effort, unable to procure policies to cover the kind or kinds of business required from companies duly authorized to transact business in the District. Each agent or broker so licensed shall pay to the Collector of Taxes, through the Commissioner, on February 1st and August 1st of each year, a sum equal to 2 per centum of the amount of the gross premiums upon all kinds of policies procured by him during the immediately preceding 6 months' period ending December 31st and June 30th, respectively, and, in default of such payment, the Commissioner, through the Corporation Counsel, may bring suit to recover the same. Each agent or broker so licensed to procure policies from unauthorized companies shall execute and file with the Department on or before the 10th day of each month an affidavit covering the transactions of the previous calendar month, setting forth:

(1) The description and location of the insured property or risk, and the name of the assured;

(2) The amount insured in the policy or contract;

(3) The gross premiums charged thereon;

(4) The name of the company whose policy or contract is issued, and the kind or kinds of business effected; and

(5) That said agent or broker after diligent effort was unable to procure the policies or contracts required to protect the property or risk described in the affidavit from companies duly authorized to transact business in the District.

(b) Each agent or broker so licensed to procure policies from unauthorized companies shall keep a separate account of the business transacted thereunder, which shall be open at all times to the inspection of the Commissioner. The license provided for in this section may be revoked or renewal thereof refused for failure to pay the tax or to file the affidavit specified herein, or if the agent or broker procured policies from unauthorized companies without exercising diligent effort to secure the required business in duly authorized companies, or if the agent or broker procured policies from unauthorized companies whose standards of solvency and management do not meet the requirements necessary for the protection of the policyholders, or if the agent or broker has placed with any unauthorized company any risk which could be placed with an authorized company except for abnormal provisions of the policy, or if the agent or broker has procured from an unauthorized company any policy which covers a risk of a class generally covered in the District by authorized companies and which authorized companies would cover at a rate not higher than that charged by authorized companies on other District risks of the same class.

(Oct. 9, 1940, 54 Stat. 1080, ch. 972, ch. II, § 40; Apr. 22, 1944, 58 Stat. 192, ch.

173, § 4; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; May 13, 2008, D.C. Law 17-155, § 3, 55 DCR 3683.)

Section references. — This section is referred to in §§ 31-231, 31-1131.07, 31-1131.08, and 31-2502.39.

Prior Codifications. — 1981 Ed., § 35-1544.

1973 Ed., § 35-1344.

Effect of amendments. — D.C. Law 17-155, in subsec. (a), substituted “A person may be licensed as a surplus lines insurance producer under Chapter 11A of this title,” for “Any agent or broker licensed in the District may, upon payment of a license fee, as provided under § 31-2502.41, be licensed”.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 17-155. — For Law 17-155, see notes following § 31-1131.02.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2501.03.

Office of Collector of Taxes abolished: See Historical and Statutory Notes following § 31-2502.03.

§ 31-2502.41. License fees.

(a) Annual fees to be paid through the Commissioner to the District of Columbia for licenses issued under this chapter shall include a \$250 annual renewal fee for registration and certification for Risk Retention and Purchasing Groups and any other fee established pursuant to subsection (e) of this section.

(b) Repealed.

(c) Repealed.

(d) Repealed.

(e) The Commissioner may promulgate rules to establish and amend all producer and license fees.

(Oct. 9, 1940, 54 Stat. 1081, ch. 792, ch. II, § 41; Feb. 23, 1980, D.C. Law 3-52, § 6, 27 DCR 26; June 14, 1994, D.C. Law 10-128, § 403(a), 41 DCR 2096; Apr. 18, 1996, D.C. Law 11-110, § 61(a), 43 DCR 530; May 21, 1997, D.C. Law 11-268, § 10(r)(2), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 29(c), 45 DCR 745; Mar. 8, 2007, D.C. Law 16-232, § 202(c), 54 DCR 368.)

Cross references. — Refund of fees when license refused, see § 47-1318.

Prior Codifications. — 1981 Ed., § 35-1545.

1973 Ed., § 35-1345.

Effect of amendments. — D.C. Law 16-232 rewrote subsecs. (a) and (e), and repealed subsec. (b) to (d).

Legislative history of Law 3-52. — For legislative history of D.C. Law 3-52, see Historical and Statutory Notes following § 31-2502.14.

Legislative history of Law 10-128. — Law 10-128, the “Omnibus Budget Support Act of 1994,” was introduced in Council and assigned Bill No. 10-575, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on March 22, 1994, and April 12, 1994, respectively. Signed by the Mayor on April 14, 1994, it was assigned Act No. 10-225 and transmitted to both Houses of

Congress for its review. D.C. Law 10-128 became effective on June 14, 1994.

Legislative history of Law 11-110. — Law 11-110, the “Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2502.11.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

abolished: See Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — Department of Insurance

§ 31-2502.42. Violations of provisions.

(a) Any person who violates any of the provisions of this chapter, or fails to comply with any duty imposed upon such person by any of the provisions of this chapter, for which violation or failure no penalty is elsewhere provided by this chapter, or by the laws of the District, shall, upon conviction thereof, be fined for each offense not exceeding \$1,000 or be imprisoned for not more than 12 months, or both. Prosecutions authorized by this section shall be upon information filed in the Superior Court of the District of Columbia by the Corporation Counsel or any of his assistants.

(b) Civil fines, penalties, and fees may be imposed as alternative sanctions for any infraction of the provisions of this chapter, or any rules or regulations issued under the authority of this chapter, pursuant to Chapter 18 of Title 2. Adjudication of any infraction of this chapter shall be pursuant to Chapter 18 of Title 2.

(Oct. 9, 1940, 54 Stat. 1082, ch. 792, ch. II, § 43; Apr. 1, 1942, 56 Stat. 190, ch. 207, § 1; July 8, 1963, 77 Stat. 77, Pub. L. 88-60, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); Oct. 5, 1985, D.C. Law 6-42, § 447(c), 32 DCR 4450; Mar. 8, 1991, D.C. Law 8-237, § 2(r)(3), 38 DCR 314.)

Cross references. — Violation of credit life, accident, and health insurance provisions, penalties, see § 31-5111.

Section references. — This section is referred to in § 31-1103.

Prior Codifications. — 1981 Ed., § 35-1546.

1973 Ed., § 35-1347.

Legislative history of Law 8-237. — For legislative history of D.C. Law 8-237, see Historical and Statutory Notes following § 31-2502.03.

§§ 31-2502.43 to 31-2502.45. Appeals from Commissioner to Mayor; court proceedings; severability. [Repealed].

Repealed.

(April 9, 1997, D.C. Law 11-227, § 16(c), 44 DCR 140.)

Prior Codifications. — 1981 Ed., §§ 35-1547 to 35-1549.

Legislative history of Law 11-227. — For legislative history of D.C. Law 11-227, see Historical and Statutory Notes following § 31-2502.30.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2501.03.

Editor's notes. — Former § 35-1547 1981 Ed. was also amended by D.C. Law 11-268, § 10(r)(2), eff. May 21, 1997. D.C. Law 11-268 amended former § 35-1547 1981 Ed. by substituting "Commissioner" for "Superintendent" in the first sentence.

D.C. Law 11-268, § 10(r)(2) (44 DCR 1730), eff. May 21, 1997, amends § 35-1547 1981 Ed. subsequent to repeal.

CHAPTER 26.. MARINE INSURANCE.

Subchapter I. Prohibitions

Subchapter II. General

Sec.

31-2601.01. Kinds of insurance prohibited.

Sec.

31-2602.01 to 31-2602.32. [Repealed].

Subchapter I. Prohibitions.

§ 31-2601.01. Kinds of insurance prohibited.

No insurance shall be made by any person or persons, bodies politic or corporate, on any ship or ships, or on any goods, merchandise, or effects laden or to be laden on board of any ship or ships, interest or no interest, or without further proof of interest than the policy, or by way of gaming or wagering or without benefit of salvage to the insurer; and every such insurance shall be null and void to all intents and purposes.

(Mar. 3, 1901, 31 Stat. 1294, ch. 854, § 656.)

Prior Codifications. — 1981 Ed., § 35-1432. 1973 Ed., § 35-1133.

Subchapter II. General.

§ 31-2602.01. Definitions. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 401, ch. 93, title I, § 1; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1401.

1973 Ed., § 35-1101.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(o) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor’s notes. — D.C. Law 15-166, § 4(o), purported to amend this section that was pre-

viously repealed by D.C. Law 14-297, therefore, the amendment was ineffective.

Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District

of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance

and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

§ 31-2602.02. Applicability of District insurance laws. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 402, ch. 93, title I, § 2; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1402.

1973 Ed., § 35-1102.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.03. Kinds of insurance authorized; reserves required; requirements for transacting business for stock companies and reinsurance corporations. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 402, ch. 93, title 2, § 3; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 28(a), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1403.

1973 Ed., § 35-1103.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first

and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1998, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.04. Organization and licensing requirements for domestic mutual companies. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 404, ch. 93, title 2, § 4; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1404.
1973 Ed., § 35-1104.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.05. Requirements for transacting business for foreign companies. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 404, ch. 93, title 2, § 5; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1405.
1973 Ed., § 35-1105.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.06. Reinsurance of risks. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-36, § 6(b), as added May 16, 1995, D.C. Law 10-255, § 26(c), 41 DCR 5193; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1406.

Legislative history of Law 10-36. — Law 10-36, the "Law on Credit for Reinsurance Act of 1993," was introduced in Council and assigned Bill No. 10-128, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-69 and transmitted to both Houses of Congress for its review. D.C. Law 10-36 became effective on October 15, 1993.

Legislative history of Law 10-255. — Law 10-255, the "Technical Amendments Act of 1994," was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.07. Computation of unearned premiums. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 405, ch. 93, title 4, § 7; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1407.
1973 Ed., § 35-1107.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.08. Taxation of companies—Tax on underwriting profit—Computation of profit. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 405, ch. 93, title 5, § 8; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1408.
1973 Ed., § 35-1108.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.09. Taxation of companies—Tax on underwriting profit—Computation and payment of tax. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 406, ch. 93, title 5, § 9; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1409.
1973 Ed., § 35-1109.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Office of Collector of Taxes abolished: The Office of the Collector of Taxes was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Collector of Taxes including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3, dated August 28, 1952. Reorganization Order No. 20, dated November 10, 1952, transferred the functions of the Collector of Taxes to the Finance Office. The same Order provided for the Office of the Collector of Taxes headed by a Collector in the Finance Office, and abolished the previously existing Office of the Collector of Taxes. Reorganization Order No. 20 was superseded and replaced by Organization Order No. 121, dated December 12, 1957, which provided that the Finance

Office (consisting of the Office of the Finance Officer, Property Tax Division, Revenue Division, Treasury Division, Accounting Division, and Data Processing Division) would continue under the direction and control of the Director of General Administration, and that the Treasury Division would perform the function of collecting revenues of the District of Columbia and depositing the same with the Treasurer of the United States. Organization Order No. 121 was revoked by Organization Order No. 3, December 13, 1967, Part IVC of which prescribed the functions of the Finance Office within a newly established Department of General Administration. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Functions of the Finance Office as stated in Part IVC of Organization Order No. 3 were transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969. The collection functions of the Director of the Department of Finance and Revenue were transferred to the District of Columbia Treasurer by § 47-316 on March 5, 1981.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.10. Taxation of companies—Tax on average earnings on reserves for unpaid losses and unexpired premiums. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 407, ch. 93, title 5, § 10; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1410.
1973 Ed., § 35-1110.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.11. Taxation of companies—Tax on investment income from funds representing capital stock and surplus. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 408, ch. 93, title 5, § 11; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1411.
1973 Ed., § 35-1111.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.12. Taxation of companies—Computation and payment of taxes on earnings and investment income. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 408, ch. 93, title 5, § 12; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1412.
1973 Ed., § 35-1112.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.13. Single annual license fee. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 408, ch. 93, title 5, § 13; Apr. 20, 1999, D.C. Law 12-261, § 2003(hh), 46 DCR 3142; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1413.
1973 Ed., § 35-1113.

Legislative history of Law 12-261. — Law 12-261, the "Second Omnibus Regulatory Reform Amendment Act of 1998," was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on December 1, 1998, and December 15,

1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Office of Collector of Taxes abolished: See Historical and Statutory Notes following § 31-2602.09.

§ 31-2602.14. Cessation of business. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 408, ch. 93, title 5, § 14; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1414.

1973 Ed., § 35-1114.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.15. Failure to make reports or pay taxes or fees. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 408, ch. 93, title 5, § 15; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1415.

1973 Ed., § 35-1115.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.16. Exemption from District taxes or fees. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 409, ch. 93, title 5, § 16; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1416.

1973 Ed., § 35-1116.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — United States Shipping Board abolished: By Executive Order No. 6166, § 12, dated June 10, 1933, the United States Shipping Board was abolished and its functions, including those over and in respect to the United States Shipping Board Merchant Fleet Corporation, were transferred to the Department of Commerce. By §§ 201 and 204 of the Act of June 29, 1936, 49 Stat. 1987, ch. 858, the

United States Maritime Commission was created and the functions of the former United States Shipping Board, including those vested in the Department of Commerce by Executive Order No. 6166, were transferred thereto. The functions of the United States Maritime Commission were transferred to the Federal Maritime Board by Part I of Reorganization Plan No. 21 of 1950, 64 Stat. 1273. The functions of the Federal Maritime Board were transferred to the Federal Maritime Commission by § 103 of Reorganization Plan No. 7 of 1961, 75 Stat. 840.

§ 31-2602.17. Payment of federal income taxes. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 409, ch. 93, title 5, § 17; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1417.
1973 Ed., § 35-1117.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.18. Investment of capital, assets and surplus. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 409, ch. 93, title 6, § 18; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1418.
1973 Ed., § 35-1118.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.19. Acquisition, use and disposition of real estate by domestic companies. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 410, ch. 93, title 6, § 19; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 28(b), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1419.
1973 Ed., § 35-1119.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 12-81. — For

legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2602.03.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.20. Mergers or consolidations. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 410, ch. 93, title 7, § 20; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1420.
1973 Ed., § 35-1120.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.21. Establishment and maintenance of foreign agencies. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 411, ch. 93, title 8, § 21; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1421.
1973 Ed., § 35-1121.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.22. Corporations engaged exclusively in writing insurance in foreign countries. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 411, ch. 93, title 8, § 22; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1422.
1973 Ed., § 35-1122.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.23. Unauthorized transaction of insurance business. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 412, ch. 93, title 9, § 23; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1423.
1973 Ed., § 35-1123.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.24. License of agent or broker; issuance; revocation. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 412, ch. 93, title 9, § 24; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1424.

1973 Ed., § 35-1124.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.25. Licensees to maintain office and keep records; contents, inspection and confidentiality of records; violations. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 412, ch. 93, title 9, § 25; Oct. 5, 1985, D.C. Law 6-42, § 462, 32 DCR 4450; Mar. 8, 1991, D.C. Law 8-237, § 2(u), 38 DCR 314; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 28(c), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1425.

1973 Ed., § 35-1125.

Legislative history of Law 6-42. — Law 6-42, the “Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985,” was introduced in Council and assigned Bill No. 6-187, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 25, 1985, and July 9, 1985, respectively. Signed by the Mayor on July 16, 1985, it was assigned Act No. 6-60 and transmitted to both Houses of Congress for its review.

Legislative history of Law 8-237. — Law 8-237, the “Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985 Technical and Clarifying Amendments Act of 1990,” was introduced in Council and assigned Bill No. 8-203, which was referred to the Com-

mittee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 4, 1990, and December 18, 1990, respectively. Signed by the Mayor on December 27, 1990, it was assigned Act No. 8-320 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2602.03.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.26. Licensees to furnish bond. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 413, ch. 93, title 9, § 26; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1426.

1973 Ed., § 35-1126.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.27. Companies to keep classified records; violations. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 413, ch. 93, title 10, § 27; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 28(d), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1427.

1973 Ed., § 35-1127.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 12-81. — For

legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-2602.03.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.28. Violations of provisions. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 414, ch. 93, title 11, § 28; Mar. 8, 1991, D.C. Law 8-237, § 2(u), 38 DCR 314; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1428.

1973 Ed., § 35-1128.

Legislative history of Law 8-237. — For legislative history of D.C. Law 8-237, see His-

torical and Statutory Notes following § 31-2602.25.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.29. [Omitted].

Omitted.

§ 31-2602.30. Additional personnel and expenses for Insurance Department. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 414, ch. 93, title 12, § 30; May 21, 1997, D.C. Law 11-268, § 10(q), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1429.

1973 Ed., § 35-1130.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2602.01.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2602.01.

§ 31-2602.31. Severability. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 414, ch. 93, title 13, § 31; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1430.
1973 Ed., § 35-1131.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-2602.32. Right to amend or repeal chapter. [Repealed].

Repealed.

(Mar. 4, 1922, 42 Stat. 414, ch. 93, title 13, § 32; Apr. 11, 2003, D.C. Law 14-297, § 401(b), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-1431.
1973 Ed., § 35-1132.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

CHAPTER 27. REGULATION OF CASUALTY AND OTHER INSURANCE RATES.

Sec.	Sec.
31-2701. Definitions.	sured or Commissioner; grievance procedure.
31-2702. Applicability of chapter.	
31-2703. Making of rates.	31-2708. Additional powers and duties of Commissioner.
31-2704. Filing requirements of individual companies; adjustment of rates; removal of discriminations.	31-2709. Violations.
31-2705. Cooperative and concerted action authorized.	31-2710. Judicial proceedings to contest actions of Commissioner.
31-2706. [Repealed].	31-2711 to 31-2713. [Omitted].
31-2707. Information to be furnished to in-	31-2714. Exemptions and limitations.

§ 31-2701. Definitions.

In this chapter, unless the context otherwise requires:

- (1) "District" means the District of Columbia.
- (2) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.
- (3) "Insurance" includes (but is not limited to) fidelity, surety, and guaranty bonds.
- (4) "Company" means any insurer, whether stock, mutual, reciprocal, interinsurer, Lloyd's, or any other form or group of insurers.
- (5) "Policy" means an insurance policy or contract as defined by Chapter 25 of this title.
- (6) "Agent" means and shall include any individual, copartnership, or corporation acting in the capacity of or licensed as a "policy-writing agent," "soliciting agent," or "salaried company employee" as defined by Chapter 25 of this title.
- (7) "Exempt commercial risk" means a person or entity which meets one of the following criteria:
 - (A) Retains or employs a certified or qualified risk manager to negotiate insurance coverage;
 - (B) Possesses a net worth in excess of \$2 million;
 - (C) Generates annual revenues in excess of \$2 million;
 - (D) Has at least 10 employees;
 - (E) Pays annual aggregate country-wide standard insurance premiums in excess of \$10,000;
 - (F) Has total insured property value of at least \$2 million; or
 - (G) Is a nonprofit organization or public body generating annual budgeted expenditures of at least \$5 million.
- (8) "Medical malpractice insurer" means an insurer licensed to underwrite medical malpractice insurance.

(May 20, 1948, 62 Stat. 242, ch. 324, § 1; May 21, 1997, D.C. Law 11-268, § 10(t), 44 DCR 1730; Apr. 3, 2001, D.C. Law 13-265, § 201, 48 DCR 1225; May 5, 2001, D.C. Law 13-299, § 2(a), 48 DCR 2211; June 25, 2002, D.C. Law 14-153, § 2, 49 DCR 4257; June 11, 2004, D.C. Law 15-166, § 4(p), 51 DCR 2817; Mar. 14, 2007, D.C. Law 16-263, § 101(a), 54 DCR 807.)

Prior Codifications. — 1981 Ed., § 35-1701.

1973 Ed., § 35-1501.

Effect of amendments. — D.C. Law 13-265 amended the definition of exempt commercial risk.

D.C. Law 13-299 added the definition of exempt commercial risk.

D.C. Law 14-153 amended the definition of exempt commercial risk without any change.

D.C. Law 15-166, in the definition of commissioner, substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

D.C. Law 16-263 added par. (8).

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Insurance Economic Development Temporary Amendment Act of 2001 (D.C. Law 14-61, January 24, 2002, law notification 49 DCR 990).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Insurance Economic Development Emergency Amendment Act of 2001 (D.C. Act 14-131, October 2, 2001, 48 DCR 9568).

For temporary (90 day) amendment of section, see § 2 of Insurance Economic Development Congressional Review Emergency Amendment Act of 2001 (D.C. Act 14-218, December 21, 2001, 49 DCR 393).

For temporary (90 day) amendment of section, see § 4(p) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings

on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21,

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Section 3 of D.C. Law 14-153 provided: "Section 2 shall apply as of May 15, 2001."

CASE NOTES

Insurance.

District of Columbia Superintendent of Insurance had statutory authority to issue order including "crime lines" within definition of basic property insurance under the Insurance Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the national insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. District of Columbia Ins.

Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including "crime lines" within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. District of Columbia Ins. Placement

Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

§ 31-2702. Applicability of chapter.

This chapter shall apply to all forms of fire, casualty, motor vehicle, explosion, sprinkler leakage, and inland marine insurance in the District and to all forms of insurance within the scope of Chapter 25 of this title; provided, that this chapter shall not apply to reinsurance other than joint reinsurance to the extent provided in this chapter, and shall not apply to:

(1) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies;

(2) Title insurance;

(3) Accident and health insurance;

(4) Insurance against loss of or damage to aircraft or to liability, other than workmen's compensation and employers' liability, arising out of the ownership, maintenance, or use of aircraft; and

(5) To insurance issued to self-insurers and insuring against loss in excess of at least \$10,000 resulting from any 1 accident or event, except when rates therefor are made by a rating organization.

(May 20, 1948, 62 Stat. 242, ch. 324, § 2; Oct. 21, 1993, D.C. Law 10-40, § 14, 40 DCR 6009.)

Prior Codifications. — 1981 Ed., § 35-1702.

1973 Ed., § 35-1502.

Legislative history of Law 10-40. — Law 10-40, the "Insurance Regulatory Trust Fund Act of 1993," was introduced in Council and assigned Bill No. 10-93, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-75 and transmitted to both Houses of Congress for its review. D.C. Law 10-40 became effective on October 21, 1993.

CASE NOTES

Location.

District of Columbia regulation generally precluding the insurance company from considering geographic location in determining whether to insure or continue to insure auto, fire and casualty risks in district and prohibiting cancellation of those policies for other than specified conditions do not conflict with specific provisions of the District of Columbia Insurance Code or the Automobile Insurance Plan and were not preempted thereby; with respect to basic property insurance regulation prohibiting geographic discrimination did conflict with and was preempted by the District of Columbia Insurance Placement Act. D.C. Code §§ 1-226, 35-1503(c), 35-1505, 35-1505(d), 35-1701 et seq.; National Housing Act, § 1201, 12

U.S.C. § 1749bbb. *Firemen's Ins. Co. v. Washington*, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

District of Columbia city council did not have authority under either its police power or the Insurance Code to pass insurance regulations designed to prohibit geographic discrimination and arbitrary cancellation of policies within the District. Reorganization Plan No. 3 of 1967, §§ 402(4), 406, D.C. Code Tit. 1, Appendix I; D.C. Code §§ 1-226, 35-102, 35-1701 to 35-1711. *Firemen's Ins. Co. v. Washington*, 333 F. Supp. 951, 1971 U.S. Dist. LEXIS 11190 (1971), affirmed in part and reversed in part by 483 F.2d 1323, 157 U.S. App. D.C. 320, 1973 U.S. App. LEXIS 8554 (1973).

§ 31-2703. Making of rates.

(a) Rates for insurance within the scope of this chapter shall not be excessive, inadequate, or unfairly discriminatory.

(b) Due consideration shall be given to past and prospective loss experience within and outside the District, to physical hazards, to safety and loss prevention factors, to underwriting practice and judgment, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by companies to their policyholders, members, or subscribers; to past and prospective expenses both country-wide and those specially applicable to the District; to whether classification rates exist generally for the risks under consideration; to the rarity or peculiar characteristics of the risks; and to all other relevant factors within and outside the District. Due consideration shall be given to the net investment income (including the realized capital gains) on all cash and invested assets held against all unearned premium reserves and loss reserves of any nature. Unrealized capital gains or losses shall not be considered in the rate-making process.

(c) Nothing in this section shall be taken to prohibit as unfairly discriminatory the establishment of classifications or modifications of classifications of risks based upon the size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations attributable to such risks provided such classifications and modifications apply to all risks under the same or substantially similar circumstances or conditions.

(d) Nothing in this chapter shall be construed to require uniformity in insurance rates, classifications, rating plans, or practices.

(e) Nothing in this chapter shall abridge or restrict the freedom of contract of companies, agents, brokers, or employees with reference to the commissions or salaries to be paid to such agents, brokers, or employees by companies.

(f)(1) Every classification plan fixed, established, and promulgated by the Commissioner shall be so structured as to produce rates or premium charges which are adequate, not excessive, and not unfairly discriminatory.

(2) Every final rate or premium charge proposed to be used by any motor vehicle insurer shall be filed with the Commissioner and shall be adequate, not excessive, and not unfairly discriminatory. A motor vehicle insurance rate may be held by the Commissioner to be excessive if the rate is unreasonably high for the insurance provided and is not actuarially justified based on the commonly accepted actuarial principles. In determining whether rates comply with standards under this subsection, due consideration shall be given for past and prospective loss experience within and outside the District, a reasonable margin for underwriting profit and contingencies, dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders or members or subscribers, past and prospective expenses, both countrywide and in the District, and investment income earned or realized by insurers both from their unearned premiums and from their loss reserve funds. If the Commissioner finds after a hearing that a rate is not in compliance with

this subsection, he shall order that its use be discontinued for any policy issued or renewed after a date specified in the order and the order may prospectively provide for premium adjustment of any policy then in force.

(f-1)(1)(A) Every final rate or premium charge proposed to be used by a medical malpractice insurer shall be filed with the Commissioner and shall be adequate, not excessive, and not unfairly discriminatory. A medical malpractice rate shall be excessive if the rate is unreasonably high for the insurance provided. In determining whether rates are adequate, not excessive, and not unfairly discriminatory, due consideration shall be given to:

- (i) Past and prospective loss experience within the District;
- (ii) A reasonable margin for underwriting profit and contingencies;
- (iii) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;
- (iv) Past and prospective expenses in the District;
- (v) All investment income reasonably attributable to medical malpractice insurance in the District.

(B) If District experience is not credible, the Commissioner may consider experience outside the District. The Commissioner shall promulgate rules setting forth the extent to which and the circumstances under which an insurer may rely on experience outside the District.

(2) If a medical malpractice insurer wishes to change a rate, it shall file a complete rate application with the Commissioner. A complete rate application shall include all information, including all actuarial data, projections, and assumptions, that the medical malpractice insurer has relied on in calculating its proposed rates. All such information shall be made available when filed in accordance with subchapter II of Chapter 5 of Title 2.

(3) The Commissioner shall notify the public of any application by a medical malpractice insurer for a rate change increase. The application shall be deemed approved 60 days after public notice unless the proposed rate change increase exceeds 10%. If the proposed rate change increase exceeds 10%, the Commissioner shall hold a hearing on the proposed change and shall issue an order approving, denying, or modifying the proposed change within 90 days after public notice of the proposed change. Any person shall have a right to testify in a hearing held by the Commissioner. The Commissioner shall promulgate rules governing the public hearing.

(4) If the Commissioner finds, after a hearing, that a rate used by a medical malpractice insurer does not comply with this subsection, the Commissioner shall order the insurer to discontinue using the rate and to issue a refund to any policyholder who has paid the rate to the extent that the Commissioner has found it excessive.

(g) No company, agent, or broker shall make, issue, or deliver, or knowingly permit the making, issuance, or delivery of any policy of insurance within the scope of this chapter contrary to pertinent filings which are in effect for the company as provided in this chapter, except that upon the written application of the insured stating his reasons therefor, filed with and approved by the Commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(h) Every insurer writing motor vehicle insurance in the District shall file with the Commissioner, in such form as he shall order, complete financial records showing the amount of profit on every line of motor vehicle insurance during the previous year.

(i) The Office of the People's Counsel shall serve as advocate for consumers in rate hearings before the Commissioner and the costs associated with such advocacy shall be borne by the insurer or insurers requesting the rate hearing.

(May 20, 1948, 62 Stat. 243, ch. 324, § 3; Sept. 18, 1982, D.C. Law 4-155, § 14(a), 29 DCR 3491; Mar. 4, 1986, D.C. Law 6-96, § 3, 32 DCR 7245; May 21, 1997, D.C. Law 11-268, § 10(t), 44 DCR 1730; Sept. 20, 1996, D.C. Law 11-160, § 4, 43 DCR 3722; Mar. 14, 2007, D.C. Law 16-263, § 101(b), 54 DCR 807.)

Section references. — This section is referred to in § 31-2704.

Prior Codifications. — 1981 Ed., § 35-1703.

1973 Ed., § 35-1503.

Effect of amendments. — D.C. Law 16-263 added subsec. (f-1).

Legislative history of Law 4-155. — Law 4-155, the "Compulsory/No-Fault Motor Vehicle Insurance Act of 1982," was introduced in Council and assigned Bill No. 4-140, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first, amended first, second amended first, and second readings on May 11, 1982, May 25, 1982, June 8, 1982, and June 22, 1982, respectively. Deemed approved without Mayoral signature upon expiration of the Mayoral Review period on July 22, 1982, it was assigned Act No. 4-226 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-96. — Law 6-96, the "Compulsory/No-Fault Motor Vehicle Insurance Act of 1982 Amendments Act of 1985," was introduced in Council and assigned Bill No. 6-249, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 5, 1985, and November 19, 1985, respectively. Signed by the Mayor on November 22, 1985, it was assigned Act No. 6-104 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-160. — Law 11-160, the "Automobile Insurance Amendment Act of 1996," was introduced in Council and assigned Bill No. 11-157, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and

second readings on May 7, 1996, and June 4, 1996, respectively. Signed by the Mayor on June 26, 1996, it was assigned Act No. 11-296 and transmitted to both Houses of Congress for its review. D.C. Law 11-160 became effective on September 20, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Legislative history of Law 16-263. — For Law 16-263, see notes following § 31-2701.

Editor's notes. — Report by Commissioner of Insurance and Securities: Section 5 of D.C. Law 11-160 provided that "Within two years of September 20, 1996, the Commissioner of Insurance and Securities shall prepare and submit to the Council of the District of Columbia for its review a report on the impact of this act on the private passenger motor vehicle insurance market or any part thereof, the funding for the Office of Insurance, the District of Columbia insurance premium tax, the number of insurers doing business in the District, and the number of insurers domiciled in the District of Columbia. In preparing such report, the Commissioner may request from specific private passenger motor vehicle insurers doing business in the District, or from all such insurers, reasonable and pertinent information. Information which is proprietary to any affected insurer shall be treated as confidential by the Commissioner, but may be used in the aggregate with other information from other affected insurers for statistical or other reporting purposes."

Department of Insurance abolished: See Historical and Statutory Notes following § 35-2701.

CASE NOTES

ANALYSIS

Crime lines.

Locations.

Rate increases.

Crime lines.

District of Columbia Superintendent of Insurance had statutory authority to issue order including "crime lines" within definition of basic property insurance under the Insurance Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the national insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including "crime lines" within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Locations.

Regulation prohibiting auto, fire or casualty insurer from considering geographical location in determining whether to insure or continue to insure a risk in the District of Columbia except in cases of overconcentration of liability in a single high risk area and regulation prohibiting cancellation of auto, fire and casualty policies only for specified reasons are within the police power accorded to the District of Columbia by congressional enactment. D.C. Code § 1-226.

Firemen's Ins. Co. v. Washington, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

District of Columbia regulation generally precluding the insurance company from considering geographic location in determining whether to insure or continue to insure auto, fire and casualty risks in district and prohibiting cancellation of those policies for other than specified conditions do not conflict with specific provisions of the District of Columbia Insurance Code or the Automobile Insurance Plan and were not preempted thereby; with respect to basic property insurance regulation prohibiting geographic discrimination did conflict with and was preempted by the District of Columbia Insurance Placement Act. D.C. Code §§ 1-226, 35-1503(c), 35-1505, 35-1505(d), 35-1701 et seq.; National Housing Act, § 1201, 12 U.S.C. § 1749bbb. *Firemen's Ins. Co. v. Washington*, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

Rate increases.

Insurer which could not recoup, through an increase in premiums, additional costs which would result from invalidation of personal injury threshold for lawsuits under the District of Columbia no-fault law had inadequate interest in challenge to the law to intervene as of right. Fed.R.Civ.Proc. Rule 24(a)(2), 18 U.S.C.; D.C. Code 1981, §§ 35-1703(f)(2), 35-2105(b)(6). *Dimond v. District of Columbia*, 792 F.2d 179, 1986 U.S. App. LEXIS 25293 (C.A.D.C. 1986).

Decision by Superintendent of Insurance lowering insurer's rate increases with respect to property damage liability and collision coverage based on holding that insurer's use of a five-point exponential trend line for purposes of predicting future revenue requirements and claim demands was inadequately justified, and that previously approved of eight-point line was more appropriate was arbitrary, capricious and unsupported on the record where it could not be fairly stated that use of a five-point trend line effected a material alteration from previous policy. D.C. Code 1981, §§ 35-1703(a), 35-1704(c). *Government Employees Ins. Co. v. Montgomery*, 465 A.2d 813, 1983 D.C. App. LEXIS 443 (1983).

§ 31-2704. Filing requirements of individual companies; adjustment of rates; removal of discriminations.

(a) On and after July 1, 1948, every company shall file with the Commissioner, either directly or through a licensed rating organization of which it is a member or subscriber, except as to rates on inland marine risks which are not made by a rating organization and which by general custom of the business are

not written according to manual rates or rating plans, all rates and rating plans, rules, and classifications which it uses or proposes to use in the District.

(b) Whenever it shall be made to appear to the Commissioner, either from his own information or from complaint of any party alleging to be aggrieved thereby, that there are reasonable grounds to believe that the rates on any or on all risks or classes of risks or kinds of insurance within the scope of this chapter are not in accordance with the terms of this chapter, it shall be his duty, and he shall have the full power and authority, to investigate the necessity for an adjustment of any or all such rates.

(c)(1) After an investigation of the rates, the Commissioner shall, before ordering an adjustment, hold a hearing upon not less than 10 days' written notice specifying the matters to be considered at the hearing, to every company and rating organization which filed the rates; provided, that the Commissioner shall not be required to hold the hearing if he or she is advised by every such company and rating organization that they do not desire the hearing. The cost of the hearing shall be borne by the insurance company requesting the rate increase. If, after the hearing, the Commissioner determines that any or all of the rates are excessive or inadequate, he or she shall order an adjustment. Pending the investigation and order of the Commissioner, the rates shall be deemed to have been made in accordance with the terms of this chapter.

(2)(A) An order of adjustment shall not affect any contract or policy made or issued prior to the effective date of the order unless:

(i) The adjustment is substantial and exceeds the cost to the companies of making the adjustment; and

(ii) The order is made after the prescribed investigation and hearing and within 30 days after the filing of rates affected.

(B) An order of adjustment shall not affect an existing contract or policy other than:

(i) A medical malpractice, workmen's compensation, or automobile liability insurance policy required by law, order, rule, or regulation of a public authority; or

(ii) A contract or policy of any type as to which the rates are not, by general custom of the business or because of rarity and peculiar characteristics, written according to normal classification or rating procedure.

(d) In determining the necessity for an adjustment of rates, the Commissioner shall be bound by all of the provisions of § 31-2703.

(e) The Commissioner is further empowered to investigate and to order removed at such time and in such manner as he shall specify any unfair discrimination existing between individual risks or classes of risks.

(May 20, 1948, 62 Stat. 243, ch. 324, § 4; May 21, 1997, D.C. Law 11-268, § 10(t), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 30(a), 45 DCR 745; Mar. 14, 2007, D.C. Law 16-263, § 101(c), 54 DCR 807.)

Prior Codifications. — 1981 Ed., § 35-1704.

1973 Ed., § 35-1504.

Effect of amendments. — D.C. Law 16-263 rewrote subsec. (c) which had read as follows:

"(c) After such an investigation of any such rates, the Commissioner shall, before ordering any appropriate adjustment thereof, hold a hearing upon not less than 10-days written notice specifying the matters to be considered

at such hearing, to every company and rating organization which filed such rates, provided the Commissioner need not hold such hearing in the event he is advised by every such company and rating organization that they do not desire such hearing. If after such hearing the Commissioner determines that any or all of such rates are excessive or inadequate, he shall order appropriate adjustment thereof. Pending such investigation and order of the Commissioner, rates shall be deemed to have been made in accordance with the terms of this chapter. No order of adjustment shall affect any contract or policy made or issued prior to the effective date of such order unless: (1) the adjustment to be effected is substantial and exceeds the cost to the companies of making the adjustment; and (2) the order is made after the prescribed investigation and hearing and within 30 days after the filing of rates affected. In no event shall an order of adjustment affect an existing contract or policy other than one of workmen's compensation or automobile liability insurance required by law, order, rule, or regulation of a public authority, or a contract or

policy of any type as to which the rates are not, by general custom of the business or because of rarity and peculiar characteristics, written according to normal classification or rating procedure."

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 16-263. — For Law 16-263, see notes following § 31-2701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2701.

CASE NOTES

ANALYSIS

Adjustment of rates.

Crime lines.

Expansion of coverage.

Geographic discrimination.

Adjustment of rates.

Decision by Superintendent of Insurance lowering insurer's rate increases with respect to property damage liability and collision coverage based on holding that insurer's use of a five-point exponential trend line for purposes of predicting future revenue requirements and claim demands was inadequately justified, and that previously approved of eight-point line was more appropriate was arbitrary, capricious and unsupported on the record where it could not be fairly stated that use of a five-point trend line effected a material alteration from previous policy. D.C. Code 1981, §§ 35-1703(a), 35-1704(c). *Government Employees Ins. Co. v. Montgomery*, 465 A.2d 813, 1983 D.C. App. LEXIS 443 (1983).

Crime lines.

District of Columbia Superintendent of Insurance had statutory authority to issue order including "crime lines" within definition of basic property insurance under the Insurance Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the na-

tional insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including "crime lines" within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Expansion of coverage.

Provision in District of Columbia fair access to insurance requirements plan that Superintendent of Insurance may not adopt procedures conflicting with minimum administrative procedures for the operation of the fair plans is not to be construed as preventing Superintendent from proceeding toward an expansion of insurance coverage as provided in the Act. D.C. Code

§ 35-1704(b). District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Geographic discrimination.

Where Congress provided for the equitable distribution of responsibility for insuring qualified property within the District of Columbia for which insurance could not be obtained through the normal market by passing the

Insurance Placement Act, the city council of the District could not thereafter regulate the same type of high risk coverage by passing regulation designed to prohibit geographic discrimination. D.C. Code § 35-1704. Firemen's Ins. Co. v. Washington, 333 F. Supp. 951, 1971 U.S. Dist. LEXIS 11190 (1971), affirmed in part and reversed in part by 483 F.2d 1323, 157 U.S. App. D.C. 320, 1973 U.S. App. LEXIS 8554 (1973).

§ 31-2705. Cooperative and concerted action authorized.

(a) Subject to the provisions of this chapter, 2 or more companies may cooperate or act in concert with each other:

(1) As a rating organization, for the purpose of making rates, rating plans, or rating systems. No company shall be deemed to be a rating organization;

(2) As an advisory organization, for the purpose of preparing policy forms, making underwriting rules, surveys, or inspections incident to but not including the making of rates, rating plans, or rating systems, or collecting and furnishing to companies or rating organizations loss or expense statistics or other statistical data, and acting in an advisory as distinguished from a rate making capacity;

(3) As a group or fleet of companies operating under the same general management and control, for the purpose of conducting a complete insurance service;

(4) As a group, association, or other organization for the purpose of joint underwriting or joint reinsurance, or of equitable apportionment and proper rating of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods.

(b) No company shall be required by this chapter to be a member or subscriber of any rating organization.

(May 20, 1948, 62 Stat. 244, ch. 324, § 5.)

Prior Codifications. — 1981 Ed., § 35-1705. 1973 Ed., § 35-1505.

§ 31-2706. Filing requirements of organizations of companies; unfair practices; supervision of rating organizations. [Repealed].

Repealed.

(May 20, 1948, 62 Stat. 245, ch. 324, § 6; Mar. 21, 1995, D.C. Law 10-233, § 7, 42 DCR 24; Apr. 18, 1996, D.C. Law 11-110, § 39, 43 DCR 530; Apr. 9, 1997, D.C. Law 11-255, § 40, 44 DCR 1271; May 21, 1997, D.C. Law 11-268, § 10(t), 44DCR 1730; Apr. 20, 1999, D.C. Law 12-261, § 2003(jj), 46 DCR 3142; Apr. 3, 2001, D.C. Law 13-265, § 126(c), 48 DCR 1225, redesignated § 303, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-1706.

1973 Ed., § 35-1506.

Emergency legislation. — For purported temporary (90 day) amendment of section, see § 3(x) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of 1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 11-110. — Law 11-110, the “Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Legislative history of Law 11-255. — Law 11-255, the “Second Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-519 and transmitted to both Houses of Congress for its review. D.C. Law 11-255 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Legislative history of Law 12-261. — Law 12-261, the “Second Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of

Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

Editor's notes. — D.C. Act 15-145, § 3(x) and D.C. Law 15-38, § 3(x), purported to amend subsec. (c)(5) of this section previously repealed by D.C. Law 14-213.

Office of Collector of Taxes abolished: The Office of the Collector of Taxes was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Collector of Taxes including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3, dated August 28, 1952. Reorganization Order No. 20, dated November 10, 1952, transferred the functions of the Collector of Taxes to the Finance Office. The same Order provided for the Office of the Collector of Taxes headed by a Collector in the Finance Office, and abolished the previously existing Office of the Collector of Taxes. Reorganization Order No. 20 was superseded and replaced by Organization Order No. 121, dated December 12, 1957, which provided that the Finance Office (consisting of the Office of the Finance Officer, Property Tax Division, Revenue Division, Treasury Division, Accounting Division, and Data Processing Division) would continue under the direction and control of the Director of General Administration, and that the Treasury Division would perform the function of collecting revenues of the District of Columbia and depositing the same with the Treasurer of the United States. Organization Order No. 121, was revoked by Organization Order No. 3, dated December 13, 1967, Part IVC of which prescribed the functions of the Finance Office within a newly established Department of General Administration. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Functions of the Finance Office as stated in Part IVC of Organization Order No. 3 were transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969. The collection functions of the Director of the Department of Finance and Revenue were transferred to the District of Columbia Treasurer by § 47-316 on March 5, 1981.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-2701.

§ 31-2707. Information to be furnished to insured or Commissioner; grievance procedure.

(a) Every rating organization and every company which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(b) Every rating organization and every company which makes its own rates shall provide within the District reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his authorized representative, on his written request to revise the manner in which such rating system has been applied in connection with the insurance afforded him. If the rating organization or company fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such rating organization or such company on such request may, within 30 days after written notice of such action, appeal to the Commissioner, who, after a hearing held upon not less than 10 days written notice to the appellant and to such rating organization or company, may affirm or reverse such action.

(c) No company, agent, broker, or rating organization may willfully withhold required information from or give false or misleading information to the Commissioner.

(d) No company, agent, or broker shall fail to furnish to an insured any policy or comparable evidence of insurance to which the insured is entitled.

(May 20, 1948, 62 Stat. 246, ch. 324, § 7; May 21, 1997, D.C. Law 11-268, § 10(t), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1707.

1973 Ed., § 35-1507.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-2701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2701.

CASE NOTES

ANALYSIS

Renewal of licenses.
Review.

Renewal of licenses.

Where evidence amply supported finding that policy-writing agent for insurance company violated insurance laws by failing to furnish policies or comparable evidence of insurance to which insured persons were entitled and that agent represented that it had authority to solicit and procure policies of insurance when it had no license to do so, refusal of Superintendent of Insurance to renew agent's license was proper. D.C. Code 1940, §§ 35-

1336, 35-1339, 35-1340, 35-1507(d). *Columbia Auto Loan v. Jordan*, 196 F.2d 568, 1952 U.S. App. LEXIS 2496 (C.A.D.C. 1952).

Due process of law did not entitle policy-writing agent to a formal hearing before Superintendent of Insurance of the District of Columbia when Superintendent refused to renew agent's license in view of the fact that under statute administrative action could be challenged in federal court in any or every respect in which the order might be invalid, and in view of the fact that agent had right to de novo hearing to explore evidence on which Superintendent acted, and reasons and calculations on which he reached his conclusions. D.C. Code 1940, §§ 35-1340, 35-1349. *Columbia Auto*

Loan v. Jordan, 196 F.2d 568, 1952 U.S. App. LEXIS 2496 (C.A.D.C. 1952).

Review.

Where Superintendent of Insurance of the District of Columbia refused to renew license of policy-writing agent for an insurance company, and agent, in bringing suit in federal district court to review the action of the Superinten-

dent chose to frame his complaint broadly and seek the fullest measure of relief, court did not err in conducting a de novo trial which explored grounds beyond those on which the Superintendent rested his refusal to renew. D.C. Code 1940, §§ 35-1340, 35-1349. Columbia Auto Loan v. Jordan, 196 F.2d 568, 1952 U.S. App. LEXIS 2496 (C.A.D.C. 1952).

§ 31-2708. Additional powers and duties of Commissioner.

(a) In addition to any powers hereinbefore expressly enumerated in this chapter, the Commissioner shall have full power and authority, and it shall be his duty, to enforce by regulations made and promulgated by the Council of the District of Columbia, by orders, or otherwise all and singular, the provisions of this chapter, and the full intent thereof. In particular he shall have the authority and power:

(1) To examine all records of companies and rating organizations and to require any or every company, agent, broker, and rating organization to furnish under oath such information as he may deem necessary for the administration of this chapter. The expense of such examination shall be paid by the company or rating organization examined. In lieu of such examination the Commissioner may, in his discretion, accept a report of examination made by any other insurance supervisory authority;

(2) The Council of the District of Columbia shall have the authority and power to make, and the Commissioner shall have the authority and power to enforce, such reasonable orders, rules, and regulations as may be necessary in making this chapter effective, but such orders, rules, and regulations shall not be contrary to or inconsistent with the provisions of this chapter;

(3) To issue an order, after a full hearing to all parties in interest, requiring any group, association, or organization of companies and the members thereof to cease and desist from any unfair or unreasonable practice.

(b) The Commissioner may designate 1 or more rating organizations or other agencies to assist him in gathering statistical data and in making such compilations thereof as may be necessary for the proper administration of this chapter. Such compilations shall be made available, subject to reasonable rules promulgated by the Council of the District of Columbia, to companies and rating organizations.

(c) The Commissioner shall have no authority at any hearing to compel the attendance of witnesses and he shall not be required to adhere to formal rules of pleading or evidence. At the request of a party or parties in interest made prior to any hearing, he shall administer oaths to witnesses and shall permit such party or parties, at the cost and expense of one who so requests, to have made a record of the hearing, which record upon request of such party or parties the Commissioner shall certify.

(May 20, 1948, 62 Stat. 246, ch. 324, § 8; May 21, 1997, D.C. Law 11-268, § 10(t), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1708.

1973 Ed., § 35-1508.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2701.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 402(279) of Reorganization Plan No. 3 of 1967 (see Reor-

ganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to the District of Columbia Council, subject to the right of the Commissioner as provided in § 406 of the Plan. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

Adjustment of rates.

Decision by Superintendent of Insurance lowering insurer's rate increases with respect to property damage liability and collision coverage based on holding that insurer's use of a five-point exponential trend line for purposes of predicting future revenue requirements and claim demands was inadequately justified, and that previously approved of eight-point line

was more appropriate was arbitrary, capricious and unsupported on the record where it could not be fairly stated that use of a five-point trend line effected a material alteration from previous policy. D.C. Code 1981, §§ 35-1703(a), 35-1704(c). *Government Employees Ins. Co. v. Montgomery*, 465 A.2d 813, 1983 D.C. App. LEXIS 443 (1983).

§ 31-2709. Violations.

Any company, broker, or agent guilty of violating any of the provisions of this chapter or any order, rule, or regulation issued pursuant to this chapter shall be subject to the provisions of §§ 31-2502.03 and 31-2502.36 [repealed], respectively.

(May 20, 1948, 62 Stat. 247, ch., 324, § 9.)

Prior Codifications. — 1981 Ed., § 35-1709.

1973 Ed., § 35-1509.

§ 31-2710. Judicial proceedings to contest actions of Commissioner.

Any person, firm or corporation aggrieved by any order, ruling, proceeding, or action of the Commissioner may contest the validity of such order, ruling, proceeding, or action in any court of competent jurisdiction by appeal or through any other appropriate proceedings, as provided under § 31-2502.44 [repealed].

(May 20, 1948, 62 Stat. 247, ch. 324, § 10; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 30(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-1710.

1973 Ed., § 35-1510.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-2701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-2704.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-2701.

§§ 31-2711 to 31-2713. [Omitted].

§ 31-2714. Exemptions and limitations.

(a) An insurer shall not be required to file with, or to receive approval from, the Commissioner, for rates and policy forms used in the insurance of exempt commercial risks.

(b) The filing and review exemption set forth in subsection (a) of this section shall not apply to workers' compensation and employer's liability policies and rates.

(c)(1) All policies issued under this chapter shall contain a notice to the insured that the rate and policy form are not subject to the filing, review, and approval requirements of the Commissioner.

(2) An insurer providing a policy under this chapter shall, at the time of entering into the policy agreement and annually thereafter, on a form to be prescribed by the Commissioner, which form clearly sets forth the standards of this chapter; the right of the policyholder to obtain regulatory review under this chapter; the effects of the waiver of the regulatory review; and any other information the Commissioner considers useful; and obtain a written certification signed by the policyholder certifying that the policyholder:

(A) Employs a certified or qualified risk manager or placed the business through a licensed insurance producer or otherwise meets the criteria of an exempt commercial risk;

(B) Is aware that the policy being purchased is not subject to initial regulatory review or approval of rates and forms; and

(C) Agrees to the use of the exempt rates and forms by its insurer.

(3) The policyholder certification shall be filed with, and retained by, the insurance company issuing coverage to the policyholder. An insurer issuing policies under this section shall provide the number of exempt policyholders annually to the Commissioner.

(d) If any provision of this section conflicts with any other law in the District, this section shall govern.

(May 20, 1948, 62 Stat. 242, ch. 324, § 14, as added May 5, 2001, D.C. Law 13-299, § 2(b), 48 DCR 2211; Oct. 19, 2002, D.C. Law 14-213, § 21, 49 DCR 8140.)

Effect of amendments. — D.C. Law 14-213 validated a previously made technical change in directory language of D.C. Law 13-299 which required no change in text.

Legislative history of Law 13-299. — For

D.C. Law 13-299, see notes following § 31-2701.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

SUBTITLE IV. HEALTH AND RELATED INSURANCE.

CHAPTER 28. ACCESS TO EMERGENCY MEDICAL SERVICES.

Sec.

31-2801. Definitions.

31-2802. Covered services.

Sec.

31-2803. Emergency department HIV screening.

§ 31-2801. Definitions.

For the purposes of this chapter, the term:

(1) "Ancillary services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

(2) "Emergency services" means:

(A) Health care services furnished in the emergency department of a hospital for the treatment of a medical emergency;

(B) Ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and

(C) Emergency medical services transportation.

(3) "Medical emergency" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(Sept. 11, 1998, D.C. Law 12-145, § 2, 45 DCR 3785.)

Prior Codifications. — 1981 Ed., § 35-4801.

Legislative history of Law 12-145. — Law 12-145, the "Access to Emergency Medical Services Act of 1998," was introduced in Council and assigned Bill No. 12-193, which was referred to the Committee on Consumer and

Regulatory Affairs. The Bill was adopted on first and second reading on April 7, 1998 and May 5, 1998, respectively. Signed by the Mayor on May 6, 1998, it was assigned Act No. 12-356, and transmitted to both Houses of Congress for review. D.C. Law 12-145 became effective on September 11, 1998.

§ 31-2802. Covered services.

(a) All health insurers, hospitals or medical services corporations, and health maintenance organizations shall reimburse for emergency services that are due to a medical emergency.

(b) A hospital emergency department or emergency medical service transporter shall provide a health insurer, hospital or medical services corporation, or health maintenance organization with any claim for reimbursement of services, and information on the presenting symptoms of the insured as well as the services provided.

(c) A health insurer, hospital or medical services corporation, or health maintenance organization shall consider both the presenting symptoms and

the services provided in processing a claim for reimbursement of emergency services.

(d) A health insurer, hospital or medical services corporation, or health maintenance organization may not deny reimbursement, except for co-payments, deductibles, and co-insurance, for the provision of emergency services that are due to a medical emergency solely because the member failed to obtain pre-authorization for emergency services from the health insurer, hospital or medical services corporation, or health maintenance organization.

(Sept. 11, 1998, D.C. Law 12-145, § 3, 45 DCR 3785.)

Prior Codifications. — 1981 Ed., § 35-4802. legislative history of D.C. Law 12-145, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-145. — For 2801.

§ 31-2803. Emergency department HIV screening.

(a) For the purposes of this section, the term.

(1) “Health benefit plan,” “health insurer,” and “insured” shall have the same meanings as provided in § 31-3001.

(2) “HIV screening test” shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

(A) Conducting a rapid-result test by means of the swabbing of a patient’s gums, finger-prick blood test, or other suitable rapid-result test; and

(B) If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

(b) A health benefit plan shall reimburse the cost of a voluntary HIV screening test performed on its insured while the insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the insured to seek emergency services.

(c) The benefits mandated by subsection (b) of this section shall:

(1) Include at least one annual emergency department HIV screening test;

(2) Reimburse the costs of administering such a test, all laboratory expenses to analyze the test, and the costs of communicating to the patient the results of the test and any applicable follow-up instructions for obtaining health care and supportive services; and

(3) Not be subject to any annual or coinsurance deductible or any co-payment other than the co-payment that the insured would have to pay for the applicable hospital emergency department visit.

(d) A representative of the emergency department of a hospital that provides emergency department HIV screening shall advise any patient between 13 and 64 years of age:

(1) That unless a patient, or in the case of a minor, the patient’s parent, legal guardian, or other person authorized to make health care decisions for the minor, chooses to withhold consent, an HIV screening test will be performed at the time he or she receives emergency medical treatment;

(2) That, if the patient is covered by a health benefit plan issued by a health insurer, the cost of at least one annual emergency department HIV screening test is a covered benefit;

(3) That the test results are confidential, except that a positive test result will be reported to the Department of Health for statistical and public health purposes; and

(4) In the case of a positive test result, where the patient may obtain appropriate health care and supportive services.

(e) A health insurer shall not:

(1) Require an insured or applicant for insurance to pay a higher deductible, copayment, or coinsurance, require a longer waiting period, or impose any other condition for coverage of benefits solely because an insured or applicant for insurance used the benefits covered by this section;

(2) Refuse to issue a health benefit plan solely because an applicant may use the benefits covered by this section; or

(3) Cancel or refuse to renew a health benefit plan solely because an insured has used the benefits covered by this section.

(f) The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, may issue rules to implement the provisions of this section.

(Sept. 11, 1998, D.C. Law 12-145, § 3a, as added Mar. 21, 2009, D.C. Law 17-316, § 2, 56 DCR 206.)

Legislative history of Law 17-316. — Law 17-316, the “Insurance Coverage for Emergency Department HIV Testing Amendment Act of 2008”, was introduced in Council and assigned Bill No. 17-487 which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and

second readings on November 18, 2008, and December 2, 2008, respectively. Signed by the Mayor on December 22, 2008, it was assigned Act No. 17-620 and transmitted to both Houses of Congress for its review. D.C. Law 17-316 became effective on March 21, 2009.

CHAPTER 29. CANCER PREVENTION.

Subchapter I. Screening for Women

Sec.

31-2901. Definitions.

31-2902. Payable benefits.

31-2903. Applicability.

Subchapter II. Colorectal Cancer Screening Insurance

31-2931. Coverage.

Subchapter III. Prostate Cancer Screening Insurance

Sec.

31-2951. Definitions.

31-2952. Coverage for prostate cancer screening.

31-2953. Applicability.

31-2954. Regulations.

*Subchapter I. Screening for Women.***§ 31-2901. Definitions.**

For the purposes of this subchapter, the term:

(1) "Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations.

(2) "Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast.

(3) "Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.

(4) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(Mar. 7, 1991, D.C. Law 8-225, § 2, 38 DCR 217; June 18, 2003, D.C. Law 14-312, § 401(a), 50 DCR 306.)

Prior Codifications. — 1981 Ed., § 35-2401.

Effect of amendments. — D.C. Law 14-312 rewrote par. (4) which had read as follows: "(4) 'Health insurance policy' means any health insurance policy that provides for the payment of indemnity on account of sickness and is offered by Group Hospitalization and Medical Services, Incorporated, a health insurance com-

pany, a health self-insured, an insurance purchasing trust, or any health maintenance organization that offers insurance benefits or health plans in the District of Columbia ('District'). The term 'health insurance policy' shall not include a hospital indemnity policy, a disability insurance policy, an accident only policy, or a student accident policy."

Legislative history of Law 8-225. — Law

8-225, the "District of Columbia Cancer Prevention Act of 1990," was introduced in Council and assigned Bill No. 8-367, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 4, 1990, and

December 18, 1990, respectively. Signed by the Mayor on December 27, 1990, it was assigned Act No. 8-308 and transmitted to both Houses of Congress for its review.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-1601.

§ 31-2902. Payable benefits.

(a) Any individual or group health benefit plan, including Medicaid, shall provide health insurance benefits to cover:

- (1) A baseline mammogram for women; and
- (2) An annual screening mammogram for women.

(b) Any individual or group health benefit plan, including Medicaid, shall provide health insurance benefits to cover:

- (1) Annual cervical cytologic screening for women; and
- (2) Cervical cytologic screening for women upon certification by an attending physician that the test is medically necessary.

(c) Benefits provided in accordance with this section shall not be subject to an annual or coinsurance deductible.

(d) Benefits provided in accordance with this section shall not be subject to a co-payment except when an enrollee or subscriber elects to have a baseline mammogram, annual screening mammogram, annual cervical cytologic screening, and a cervical cytologic screening certified by an attending physician as being necessary, performed by an out-of-network provider in a preferred provider plan.

(e) Co-payments and coinsurance may be applicable to the enrollee's or subscriber's office visit.

(f) Subsections (d) and (e) of this section shall apply:

- (1) To any insurance policy or subscriber contract delivered or issued for delivery in the District more than 120 days after April 5, 2005; and
- (2) To any insurance policy or subscriber contract renewed, amended, or reissued 120 days after April 5, 2005.

(Mar. 7, 1991, D.C. Law 8-225, § 3, 38 DCR 217; June 18, 2003, D.C. Law 14-312, § 401(b), 50 DCR 306; Apr. 5, 2005, D.C. Law 15-291, § 2, 52 DCR 1457; Apr. 7, 2006, D.C. Law 16-91, § 106, 52 DCR 10637.)

Prior Codifications. — 1981 Ed., § 35-2402.

Effect of amendments. — D.C. Law 14-312, in subs. (a) and (b), substituted "health benefit plan" for "health insurance policy or service".

D.C. Law 15-291 added subs. (d), (e), and (f).

D.C. Law 16-91 made a technical correction that resulted in no change in text.

Legislative history of Law 8-225. — For legislative history of D.C. Law 8-225, see Historical and Statutory Notes following § 31-2901.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-1601.

Legislative history of Law 15-291. — Law 15-291, the "Cancer Prevention Amendment Act of 2004", was introduced in Council and assigned Bill No. 15-875, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 9, 2004, and December 7, 2004, respectively. Signed by the Mayor on December 29, 2004, it was assigned Act No. 15-686 and transmitted to both Houses of Congress for its review. D.C. Law 15-291 became effective on April 5, 2005.

Legislative history of Law 16-91. — Law 16-91, the "Technical Amendments Act of 2005", was introduced in Council and assigned Bill No. 16-477 which was referred to the Commit-

tee on the Whole. The Bill was adopted on first and second readings on November 1, 2005, and November 15, 2005, respectively. Signed by the Mayor on November 30, 2005, it was assigned

Act No. 16-212 and transmitted to both Houses of Congress for its review. D.C. Law 16-91 became effective on April 7, 2006.

§ 31-2903. Applicability.

The requirements of this subchapter shall apply:

(1) To any health benefit plan delivered or issued for delivery in the District more than 120 days after March 7, 1991; and

(2) To any health benefit plan renewed, amended, or reissued 120 days after March 7, 1991.

(Mar. 7, 1991, D.C. Law 8-225, § 4, 38 DCR 217; June 18, 2003, D.C. Law 14-312, § 401(c), 50 DCR 306.)

Prior Codifications. — 1981 Ed., § 35-2403.

Effect of amendments. — D.C. Law 14-312, in pars. (1) and (2), substituted “health benefit plan” for “insurance policy or subscriber contract”.

Legislative history of Law 8-225. — For legislative history of D.C. Law 8-225, see Historical and Statutory Notes following § 31-2901.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-1601.

Subchapter II. Colorectal Cancer Screening Insurance.

§ 31-2931. Coverage.

(a) Every individual and group health insurance policy or service, including Medicaid, shall provide coverage for colorectal cancer screening for policyholders residing in the District of Columbia.

(b) The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines.

(c) As American Cancer Society colorectal cancer screening guidelines are updated, every individual and group health insurance policy of service, including Medicaid, shall update their colorectal cancer screening benefits to comply with the American Cancer Society guidelines.

(Apr. 13, 2002, D.C. Law 14-100, § 2, 49 DCR 1008.)

Legislative history of Law 14-100. — Law 14-100, the “Colorectal Cancer Screening Insurance Coverage Requirement Act of 2002”, was introduced in Council and assigned Bill No. 14-131, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings

on December 4, 2001, and January 8, 2002, respectively. Signed by the Mayor on January 28, 2002, it was assigned Act No. 14-233 and transmitted to both Houses of Congress for its review. D.C. Law 14-100 became effective on April 13, 2002.

Subchapter III. Prostate Cancer Screening Insurance.

§ 31-2951. Definitions.

For the purposes of this subchapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance and Securities Regulation.

(2) "Health benefits plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(3) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(Mar. 25, 2003, D.C. Law 14-233, § 2, 49 DCR 9772.)

Legislative history of Law 14-233. — Law 14-233, the "Prostate Cancer Screening Insurance Coverage Requirement Act of 2002", was introduced in Council and assigned Bill No. 14-637, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on

July 2, 2002, and October 1, 2002, respectively. Signed by the Mayor on October 23, 2002, it was assigned Act No. 14-491 and transmitted to both Houses of Congress for its review. D.C. Law 14-233 became effective on March 25, 2003.

§ 31-2952. Coverage for prostate cancer screening.

(a) Each individual and group health benefits plan issued or renewed in the District of Columbia shall provide coverage for prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines.

(b) The coverage provided under this section shall not be more restrictive than or separate from coverage provided from any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

(Mar. 25, 2003, D.C. Law 14-233, § 3, 49 DCR 9772.)

Legislative history of Law 14-233. — For Law 14-233, see notes following § 31-2951.

§ 31-2953. Applicability.

This subchapter shall apply to all individual and group health benefits plans issued or renewed on or after 120 days after March 25, 2003.

(Mar. 25, 2003, D.C. Law 14-233, § 4, 49 DCR 9772.)

Legislative history of Law 14-233. — For Law 14-233, see notes following § 31-2951.

§ 31-2954. Regulations.

The Commissioner may issue rules and regulations necessary to implement the provisions of this subchapter.

(Mar. 25, 2003, D.C. Law 14-233, § 5, 49 DCR 9772.)

Legislative history of Law 14-233. — For Law 14-233, see notes following § 31-2951.

CHAPTER 29A. CLOSED MALPRACTICE CLAIMS.

Sec.

31-2991. Closed claim analysis.

§ 31-2991. Closed claim analysis.

(a) Within 180 days of march 14, 2007, the Mayor shall submit legislation to the Council for the establishment of a database of closed obstetrician/gynecologist malpractice claims reports to be submitted by providers of medical malpractice insurance.

(b) The legislation shall include a plan which shall:

(A) Contain provisions to identify trends and develop recommendations for preventative action for adverse Obstetrician/Gynecologist events;

(B) Ensure dissemination of best practices among Obstetrician/Gynecologist practitioners and facilities and shall include provisions for ensuring the implementation of these practices; and

(C) Include provisions to study recommendations based on closed Obstetrician/Gynecologist malpractice claims in other jurisdictions.

(Mar. 14, 2007, D.C. Law 16-263, § 402, 54 DCR 807.)

Legislative history of Law 16-263. — Law 16-263, the “Medical Malpractice Amendment Act of 2006”, was introduced in Council and assigned Bill No. 16-334, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on December 5, 2006, and December 19, 2006, respectively. Signed by the Mayor on December 28, 2006, it was assigned Act No. 16-619 and transmitted to both Houses of Congress for its review. D.C. Law 16-263 became effective on March 14, 2007.

CHAPTER 29B. CLINICAL TRIALS INSURANCE COVERAGE.

Sec.

31-2993.01. Definitions.

31-2993.02. Covered trials.

Sec.

31-2993.03. Right to file grievance.

§ 31-2993.01. Definitions.

For the purposes of this chapter, the term:

(1) "Approved clinical trial" means:

(A) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:

(i) The National Institutes of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) The Centers for Medicare and Medicaid Services;

(v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or

(vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

(B) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

(C) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

(2) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" shall not include accident-only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental-only or vision-only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(3) "Health insurer" means:

(A) Any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services

corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner;

(B) A provider service organization;

(C) The District of Columbia Medicaid agency;

(D) Other governmental medical assistance programs, including their contracted insurers, whether providing services on a managed care or fee-for-service basis;

(E) The District's children's health insurance program; or

(F) Any other plans covering public employees.

(4) "Qualified individual" means:

(A)(i) An individual who is a policyholder, subscriber, insured, certificate holder, or enrollee of a health benefit plan;

(ii) A beneficiary of a District of Columbia public health program; or

(iii) A covered dependent of a policyholder, subscriber, insured, certificate holder, or enrollee; and

(B) Who meets the following conditions:

(i) The individual is eligible to participate in an approved clinical trial; and

(ii) The approved clinical trial is undertaken for the purposes of the prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening illness.

(5)(A) "Routine patient care costs" means:

(i) Items, drugs, and services that are typically provided absent a clinical trial;

(ii) Items, drugs, and services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

(iii) Items, drugs, and services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

(B) Routine patient care costs shall not include:

(i) The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or

(ii) Items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

(June 5, 2008, D.C. Law 17-166, § 2, 55 DCR 5174.)

Legislative history of Law 17-166. — Law 17-166, the "Clinical Trials Insurance Coverage Amendment Act of 2008", was introduced in Council and assigned Bill No. 17-469 which was referred to the Committee on Public Service and Consumer Affairs. The Bill was adopted on

first and second readings on March 4, 2008, and April 1, 2008, respectively. Signed by the Mayor on April 14, 2008, it was assigned Act No. 17-340 and transmitted to both Houses of Congress for its review. D.C. Law 17-166 became effective on June 5, 2008.

§ 31-2993.02. Covered trials.

(a) A health insurer shall not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a qualified individual in connection with participation in an approved clinical trial. A health insurer shall not be required to pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.

(b) In the case of health care services provided by a participating provider, the payment rate shall be at the network negotiated rate, based on the member's plan design. In case of a non-participating provider, the payment shall be at the rate that the member's plan would otherwise pay to a non-participating provider for the same services, less any applicable co-payments and deductibles.

(June 5, 2008, D.C. Law 17-166, § 3, 55 DCR 5174.)

Legislative history of Law 17-166. — For Law 17-166, see notes following § 31-2993.01.

§ 31-2993.03. Right to file grievance.

This chapter shall not limit, prohibit, or modify a qualified individual's right to:

- (1) File a grievance and use an independent review process, if available;
- or
- (2) Use the independent medical review system.

(June 5, 2008, D.C. Law 17-166, § 4, 55 DCR 5174.)

Legislative history of Law 17-166. — For Law 17-166, see notes following § 31-2993.01.

CHAPTER 29C. CHEMOTHERAPY PILL COVERAGE.

Sec.

31-2995.01. Definitions.

31-2995.02. Chemotherapy pill coverage.

Sec.

31-2995.03. Applicability to group health plans.

§ 31-2995.01. Definitions.

For the purposes of this chapter, the term:

(1) "Group health plan" means an employee welfare plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(3) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of the Department of Insurance, Securities, and Banking.

(4) "Individual health plan" means a plan offering health insurance coverage offered to individuals other than in connection with a group health plan.

(Dec. 17, 2009, D.C. Law 18-98, § 2, 56 DCR 8530.)

Legislative history of Law 18-98. — Law 18-98, the "Chemotherapy Pill Coverage Act of 2009", as introduced in Council and assigned Bill No. 18-278, which was referred to the Committee on Public Services and Consumer Affairs. The bill as adopted on first and second readings on September 22, 2009, and October 6,

2009, respectively. Effective without the Mayor's signature on October 21, 2009, it was assigned Act No. 18-225 and transmitted to both Houses of Congress for its review. D.C. Law 18-98 became effective on December 17, 2009.

§ 31-2995.02. Chemotherapy pill coverage.

(a) An individual health plan or group health plan, and a health insurer offering health insurance coverage that provides coverage for prescription drugs, shall provide health insurance coverage for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and the person receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

(b) The health insurance coverage provided under this section shall be on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications, for purposes of determining deductibles, benefit

year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

(Dec. 17, 2009, D.C. Law 18-98, § 3, 56 DCR 8530.)

Legislative history of Law 18-98. — For Law 18-98, see notes following § 31-2995.01.

§ 31-2995.03. Applicability to group health plans.

This chapter shall apply to group health plans for years beginning on or after December 17, 2009.

(Dec. 17, 2009, D.C. Law 18-98, § 4, 56 DCR 8530.)

Legislative history of Law 18-98. — For Law 18-98, see notes following § 31-2995.01.

CHAPTER 29D. DEPENDENT HEALTH INSURANCE.

Sec.

31-2996.01. Definitions.

31-2996.02. Dependent child coverage.

Sec.

31-2996.03. Limitations on other coverage.

§ 31-2996.01. Definitions.

For the purposes of this chapter, the term:

(1) "Dependent child" means an insured's child by blood or by law who:

(A) Is under 26 years of age;

(B) Has no dependent of his own;

(C) Is enrolled as a full-time student at an accredited public or private institution of higher education; and

(D) Is not provided coverage, or eligible to receive coverage, as a named subscriber, insured, enrollee, or covered person under any other group health plan or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, approved July 30, 1965 (Pub. L. No. 89-871; 42 U.S.C. § 1395 et seq.), at the time dependent coverage pursuant to this chapter begins.

(2) "Group health plan" means an employee welfare plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(3) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(4) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(Oct. 26, 2010, D.C. Law 18-252, § 2, 57 DCR 8064.)

Temporary Addition of Section. — Section 2 of D.C. Law 18-203 added a section to read as follows:

"Sec. 2. Definitions.

"For the purposes of this act, the term:

"(1) 'Dependent child' means an insured's child by blood or by law who:

"(A) Is under 26 years of age;

"(B) Is unmarried;

"(C) Has no dependent of his own;

"(D) Is a resident of the District of Columbia or is enrolled as a full-time student at an

accredited public or private institution of higher education; and

"(E) Is not provided coverage, or eligible to receive coverage, as a named subscriber, insured, enrollee, or covered person under any other group health plan or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, approved July 30, 1965 (Pub. L. 89-871; 42 U.S.C. § 1395 et seq.), at the time dependent coverage pursuant to this act begins.

"(2) 'Group health plan' means an employee

welfare plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

“(3) ‘Health insurance coverage’ means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

“(4) ‘Health insurer’ means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare ar-

angement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of Insurance, Securities, and Banking.”

Section 6(b) of D.C. Law 18-203 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) addition, see § 2 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18-384, April 29,

Legislative history of Law 18-252. — Law 18-252, the “Health Insurance for Dependents Act of 2010”, was introduced in Council and assigned Bill No. 18-499, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on June 29, 2010, and July 13, 2010, respectively. Signed by the Mayor on August 3, 2010, it was assigned Act No. 18-523 and transmitted to both Houses of Congress for its review. D.C. Law 18-252 became effective on October 26, 2010.

§ 31-2996.02. Dependent child coverage.

(a) A group health plan or an individual health plan, and a health insurer offering health insurance coverage that provides coverage for dependent children, that delivers, issues for delivery, amends, or renews a health insurance policy in the District of Columbia shall make health insurance coverage available and, if requested by the policyholder, extend coverage to any dependent child of a policyholder until the dependent child is no longer a dependent child.

(b) The health insurance coverage shall provide:

(1) The same health insurance coverage benefits to a dependent child that are available to any other covered dependent; and

(2) Health insurance coverage benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

(c) Nothing in this chapter shall be construed to require:

(1) Coverage for services provided to a dependent before October 26, 2010; or

(2) That an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

(Oct. 26, 2010, D.C. Law 18-252, § 3, 57 DCR 8064.)

Temporary Addition of Section. — Section 3 of D.C. Law 18-203 added a section to read as follows:

“Sec. 3. Dependent child coverage.

“(a) A group health plan or an individual health plan, and a health insurer offering health insurance coverage that provides coverage for dependent children, that delivers, issues for delivery, amends, or renews a health insurance policy in the District of Columbia

shall make health insurance coverage available and, if requested by the policyholder, extend health insurance coverage to any dependent child of a policyholder until the dependent child is no longer a dependent child.

“(b) The health insurance coverage shall provide:

“(1) The same health insurance coverage benefits to a dependent child that are available to any other covered dependent; and

"(2) Health insurance coverage benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

"(c) Nothing in this act shall be construed to require:

"(1) Coverage for services provided to a dependent before the effective date of this act; or

"(2) That an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section."

Section 6(b) of D.C. Law 18-203 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) addition, see § 3 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18-384, April 29,

Legislative history of Law 18-252. — For history of Law 18-252, see notes under § 31-2996.01.

§ 31-2996.03. Limitations on other coverage.

This chapter shall not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in the District of Columbia.

(Oct. 26, 2010, D.C. Law 18-252, § 4, 57 DCR 8064.)

Temporary Addition of Section. — Section 4 of D.C. Law 18-203 added a section to read as follows: "Sec. 4. Limitations on other coverage. "This act shall not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in the District of Columbia."

Section 6(b) of D.C. Law 18-203 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) addition, see § 4 of Health Insurance for Dependents Emergency Act of 2010 (D.C. Act 18-384, April 29, 2010, 57 DCR 3835).

Legislative history of Law 18-252. — For history of Law 18-252, see notes under § 31-2996.01.

CHAPTER 30. DIABETES HEALTH INSURANCE COVERAGE.

Sec.

31-3001. Definitions.

31-3002. Payable benefits.

Sec.

31-3003. Nondiscrimination.

31-3004. Applicability.

§ 31-3001. Definitions.

For the purposes of this chapter, the term:

(1) "Health benefit plan" means an accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" shall not mean accident only, credit, or disability insurance; coverage of medicare services or federal employee health plans under contracts with the United States Government; medicare supplement or long-term care insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance.

(2) "Health insurer" means a person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner of the Department of Insurance, Securities, and Banking.

(3) "Insured" means a person covered by a health benefit plan.

(Oct. 21, 2000, D.C. Law 13-175, § 2, 47 DCR 6832; June 11, 2004, D.C. Law 15-166, § 4(q), 51 DCR 2817.)

Effect of amendments. — D.C. Law 15-166, in par. (2), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(q) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 13-175. — Law 13-175, the "Diabetes Health Insurance Cover-

age Expansion Act of 2000," was introduced in Council and assigned Bill No. 13-403, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 6, 2000, and July 11, 2000, respectively. Signed by the Mayor on July 26, 2000, it was assigned Act No. 13-386 and transmitted to both Houses of Congress for its review. D.C. Law 13-175 became effective on October 21, 2000.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-3002. Payable benefits.

A health benefit plan shall provide coverage for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-

using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

(Oct. 21, 2000, D.C. Law 13-175, § 3, 47 DCR 6832.)

Legislative history of Law 13-175. — For Law 13-175, see notes following § 31-3001.

§ 31-3003. Nondiscrimination.

No health insurer shall:

(1) Require an insured to pay a higher deductible, copayment, or coinsurance; require a longer waiting period; or impose any other condition for coverage of any of the benefits set forth in this chapter other than is required for other benefits covered by the insured's health benefit plan;

(2) Refuse to issue a health benefit plan solely because an applicant may use any of the benefits covered by this chapter;

(3) Cancel a health benefit plan solely because an insured has used any of the benefits covered by this chapter;

(4) Offer to pay any type of material inducement or financial incentive to an insured to discourage the insured from using any of the benefits covered by this chapter; or

(5) Offer to pay any type of financial or other material incentive to a health care provider to deny, reduce, withhold, limit, or delay to an insured any of the benefits covered by this chapter.

(Oct. 21, 2000, D.C. Law 13-175, § 4, 47 DCR 6832.)

Legislative history of Law 13-175. — For Law 13-175, see notes following § 31-3001.

§ 31-3004. Applicability.

(a) The requirements of this chapter shall apply to all health benefit plans issued, delivered, renewed, or reissued on the 91st day after October 21, 2000.

(b) All health benefit plans other than the health benefit plans specified in subsection (a) of this section shall comply with the requirements of this chapter within 180 days after the date specified in subsection (a) of this section.

(Oct. 21, 2000, D.C. Law 13-175, § 5, 47 DCR 6832.)

Legislative history of Law 13-175. — For Law 13-175, see notes following § 31-3001.

CHAPTER 30A. DISCONTINUANCE OF CLASS OF HEALTH INSURANCE POLICIES.

Sec.

31-3011. Conditions for discontinuance of class of health insurance policies.

Sec.

31-3012. Rules.

31-3013. Application.

§ 31-3011. Conditions for discontinuance of class of health insurance policies.

(a) If an insurer decides to discontinue a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, the policy of the class may be discontinued by the insurer only if:

(1) The insurer requests in such form as designated by the Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner") that the Commissioner approve the discontinuance, and the insurer receives the approval; provided, that the Commissioner shall:

(A) No sooner than 60 days after receipt of the request, grant the approval only if he or she determines that the discontinuance of the coverage of this class by the insurer is not with the intent, or as a pretext, to discontinue the coverage of any policyholder or any insured due to the claims experience or any health status-related factor relating to any policyholder or insured covered by any such policy; and

(B) Make the determination only after examining and taking into consideration the claim histories and premium rates for each policy in the class, historical profits and losses for the class of policies, comments from policyholders or others submitted to the Commissioner within 30 days after receipt of any such request, and any other information or analysis the Commissioner demands or considers relevant;

(2) The insurer, no later than the date that the request to the Commissioner under paragraph (2) of this subsection is made, provides written notice to each policyholder of this class in such market (and to all participants and beneficiaries covered under the coverage) of:

(A) The request;

(B) The earliest possible date that the Commissioner might approve the request;

(C) The earliest possible date that the coverage could be discontinued; and

(D) A statement written in plain English of the obligations of the insurer and the rights of policyholders; and

(3) The insurer, upon approval by the Commissioner of any such request:

(A) Provides written notice to each policyholder provided coverage of the class in the market (and to all participants and beneficiaries covered under the coverage) of the discontinuance at least 90 days prior to the date of discontinuance of the coverage;

(B) Offers to each policyholder of this class in the market, the option to purchase all (or, in the case of the large group market, any) other hospital,

surgical, and medical expense coverage currently being offered by the insurer to a group in the market; and

(C) In exercising the option to discontinue coverage of the class and in offering the option of coverage under another class, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered, or new insureds who may become eligible, for the coverage.

(b) If an insurer discontinues a particular class of group, or blanket policy of, hospital, surgical, or medical expense insurance offered in the small or large group market, other than where the Commissioner authorizes the discontinuance, the insurer shall be liable to the former holder or beneficiary of such policy, or to his or her estate, for compensatory damages arising from the discontinuance, plus costs and reasonable attorneys' fees, in an action which shall be commenced no later than 3 years after the date of the discontinuance. In any such action, the court may grant such injunctive relief as the court may consider proper.

(c) If major medical insurance or insurance providing major medical type benefits is discontinued, the Commissioner shall order that an extended benefit shall be provided during total disability, with respect to the sickness, injury, or pregnancy which caused the disability, of at least 18 months subsequent to the discontinuance of the insurance unless similar coverage is afforded for the total disability under another group plan.

(Apr. 8, 2011, D.C. Law 18-360, § 402, 58 DCR 896.)

Legislative history of Law 18-360. — Law 18-360, the “Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010”, was introduced in Council and assigned Bill No. 18-792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and

second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18-710 and transmitted to both Houses of Congress for its review. D.C. Law 18-360 became effective on April 8, 2011.

§ 31-3012. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18-360, § 403, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3011.

§ 31-3013. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31-3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18-360, § 404, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3011.

CHAPTER 31. DRUG ABUSE, ALCOHOL ABUSE, AND MENTAL ILLNESS
INSURANCE COVERAGE.

Sec.	Sec.
31-3101. Definitions.	31-3107. Preservation of certain benefits.
31-3102. Coverage.	31-3108. Notification of coverage and benefits.
31-3103. Drug abuse and alcohol abuse benefits.	31-3109. Filing and rate requirements.
31-3104. Mental illness benefits.	31-3110. Health maintenance organizations.
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31-3106. Certification of nonhospital residential facilities and outpatient treatment facilities.	31-3112. Excluded programs.

§ 31-3101. Definitions.

For the purposes of this chapter, the term:

(1) "Alcohol abuse" means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

(1A) "Advanced practice registered nurse" means a person licensed as a registered nurse and certified as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revisions Act of 1985 Amendment Act of 1994 or by the state or territory where the person practices as an advanced practice registered nurse.

(2) "Clinically significant" means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

(2A) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(3) "Council" means the Council of the District of Columbia.

(4) "Covered benefits" means the health-care services or treatment available to:

(A) An insured party under a health benefits plan or certificate for which the health insurer will pay part or all of the cost; or

(B) A member of a health maintenance organization as part of the membership contract.

(5) "District" means the District of Columbia.

(6) "Drug abuse" means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

(6A) "Health benefits plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or

vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6B) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(7) "Health maintenance organization" or "HMO" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollees responsibility for co-payments and deductibles, and qualifies as a health maintenance organization under Chapter 34 of Title 31.

(8) "Hospital" means a facility licensed as a hospital by the District or by any state or territory of the United States or operated by the District, any state or territory, or the United States.

(8A) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(9) "Inpatient services" means therapeutic services that are medically or psychologically necessary and that are provided in a hospital or a nonhospital residential facility to patients admitted to the hospital or nonhospital residential facility.

(10) Repealed.

(10A) "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and which employs at least 2 employees on the first day of the plan year.

(10B) "Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves and their dependents through a group health plan maintained by a large employer.

(10C) "Managed care system" means a method that a health insurer uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality and claims.

(11) "Mayor" means the Mayor of the District of Columbia.

(11A) "Medical or surgical benefits" means benefits with respect to medical or surgical services as defined under the terms of the plan or coverage, but does not include mental health benefits.

(12) "Medically or psychologically necessary" means essential for the treatment of drug abuse, alcohol abuse, or mental illness, as determined by a physician, psychologist, or social worker.

(12A) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(13) "Mental illness" means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

(14) "Nonhospital residential facility" means a facility certified by the District or by any state or territory of the United States as a qualified nonhospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term "nonhospital residential facility" includes any facility operated by the District, any state or territory, or the United States to provide these services in a residential setting.

(15) "Outpatient services" means therapeutic services that are medically or psychologically necessary and that are provided to a patient according to an individualized treatment plan that does not require the patient's admission to a hospital or a nonhospital residential facility. The term "outpatient services" refers to services that may be provided in a hospital, a nonhospital residential facility, an outpatient treatment facility, or the office of a licensed physician, psychologist, or social worker.

(16) "Outpatient treatment facility" means a clinic, counseling center, or other similar location that is certified by the District or by any state or territory as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness. The term "outpatient treatment facility" includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

(17) "Peer review" means a system based on written procedures and formally established within the professions of medicine or any of its specialties, psychology, or social work in which a committee of licensed practitioners of the profession reviews another practitioner's diagnosis and treatment in a specific case and reaches conclusions and recommendations concerning the accuracy of the diagnosis, and the necessity, appropriateness, and effectiveness of the treatment provided and proposed by the practitioner compared to alternative treatments. For the purposes of § 31-3110, the term "peer review" shall also mean the professional utilization procedure or any similar procedure employed by health maintenance organizations.

(18) "Physician" means a person licensed to practice medicine by the District pursuant to the District of Columbia Health Occupations Revision Act of 1985 or by the state or territory where the person practices medicine.

(19) "Psychologist" means a person licensed to practice psychology by the District pursuant to the District of Columbia Health Occupations Revision Act of 1985 or by the state or territory where the person practices psychology.

(19A) "Small employer" means an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. However, if the employer was not in existence throughout the

preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer reasonably expects to employ on business days in the current calendar year.

(19B) "Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves and their dependents through a group health plan maintained by a small employer.

(20) "Social worker" means a person licensed as an independent clinical social worker by the District pursuant to § 3-1208.04, or who is licensed to practice social work with authority to engage in the independent practice of psychotherapy by the state or territory where the person practices social work.

(21) Repealed.

(22) "Supplemental benefit" means health insurance coverage provided by the District to its employees in addition to the coverage provided through the Federal Employees Health Benefits Plan pursuant to § 1-621.01.

(Feb. 28, 1987, D.C. Law 6-195, § 2, 34 DCR 491; Mar. 23, 1995, D.C. Law 10-247, § 3, 42 DCR 457; May 21, 1997, D.C. Law 11-268, § 10(w), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 33, 45 DCR 745; Oct. 21, 2000, D.C. Law 13-178, § 2(a), 47 DCR 6844; June 18, 2003, D.C. Law 14-312, § 501, 50 DCR 306; June 11, 2004, D.C. Law 15-166, § 4(r), 51 DCR 2817; Mar. 8, 2007, D.C. Law 16-242, § 2(a), 54 DCR 601.)

Section references. — This section is referred to in § 44-301.01.

Prior Codifications. — 1981 Ed., § 35-2301.

Effect of amendments. — D.C. Law 13-178 added definitions contained in pars. (8A), (10A), (11A), (12A), (19A) and (19B).

D.C. Law 14-312 rewrote par. (7) which had read as follows: "(7) 'Health maintenance organization' means a public or private organization that is a qualifying health maintenance organization under federal regulations, or has been determined to be a health maintenance organization pursuant to regulations adopted by the State Health Planning and Development Agency of the District."

D.C. Law 15-166, in par. (2A), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

D.C. Law 16-242 rewrote par. (4); added pars. (6A), (6B), and (10C); and repealed par. (10).

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(a) of Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Temporary Amendment Act of 1998 (D.C. Law 12-108, May 8, 1998, law notification 45 DCR 3259).

For temporary (225 day) amendment of section, see §§ 2 to 4 of the Vendor Payment and Drug Abuse, Alcohol Abuse, and Mental Illness Coverage Temporary Act of 1998 (D.C. Law

12-181, March 26, 1999, law notification 46 DCR 3407).

Emergency legislation. — For temporary amendment of section, see § 2(a) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Emergency Amendment Act of 1998 (D.C. Act 12-274, February 19, 1998, 45 DCR 1526), and § 2(a) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Second Emergency Amendment Act of 1998 (D.C. Act 12-546, December 18, 1998, 46 DCR 497).

For temporary amendment of section see § 6(a) of the Vendor Payment and Drug Abuse, Alcohol Abuse, and Mental Illness Coverage Emergency Amendment Act of 1998 (D.C. Act 12-396, Sept. 16, 1998, 45 DCR 6952).

For temporary (90 day) amendment of section, see § 4(r) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 6-195. — Law 6-195, the "Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986," was introduced in Council and assigned Bill No. 6-195, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first, amended first, and second readings on November 5, 1986, November 18, 1986, and December 16, 1986, respectively. Signed by the Mayor on January

8, 1987, it was assigned Act No. 6-254 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-247. — Law 10-247, the “Health Occupations Revision Act of 1985 Amendment Act of 1994,” was introduced in Council and assigned Bill No. 10-598, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Vetoed by the Mayor on December 28, 1994, Council overrode the veto on January 17, 1995, and the Bill was assigned Act No. 10-394 and transmitted to both Houses of Congress for its review. D.C. Law 10-247 became effective on March 23, 1995.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 13-178. — Law 13-178, the “Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Amendment Act of 2000,” was introduced in Council and assigned Bill No. 13-534, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 6, 2000, and July 11, 2000, respectively. Signed by the Mayor on July 26, 2000, it was assigned Act No. 13-389 and transmitted to both Houses of Congress for its review. D.C. Law 13-178 became effective on October 21, 2000.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-1601.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 16-242. — Law 16-242, the “Expansion of Substance Abuse and Mental Illness Insurance Coverage Amendment Act of 2006”, was introduced in Council and assigned Bill No. 16-904, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28 2006, it was assigned Act No. 16-598 and transmitted to both Houses of Congress for its review. D.C. Law 16-242 became effective on March 8, 2007.

References in text. — The “District of Columbia Health Occupations Revision Act of 1985,” referred to in paragraphs (18) and (19), is D.C. Law 6-99.

The “District of Columbia Health Occupations Revision Act of 1985 Amendment Act of 1994,” referred to in (1A), is D.C. Law 10-247, which is codified primarily throughout Title 3, Chapter 12.

Editor’s notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

§ 31-3102. Coverage.

(a) Except as described in subsection (b) of this section, each health insurer

that offers individual or group health plans or certificates issued or delivered in the District to an employer or individual shall provide coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness.

(b) The requirements of this chapter shall not apply to dread disease policies, student policies, nursing home policies, and home health care policies.

(c) Covered benefits for drug abuse, alcohol abuse, and mental illness in insurance policies and contracts subject to this chapter shall be limited to inpatient, residential, and outpatient services certified as necessary by a physician, psychologist, advanced practice registered nurse, or social worker.

(d) Before an insured party may qualify to receive benefits under this chapter, a physician, psychologist, advanced practice registered nurse, or social worker shall certify that the individual has a drug addiction or an alcohol addiction or a mental illness and prescribe appropriate treatment, which may include referral to other treatment providers.

(e) All drug abuse, alcohol abuse, and mental illness treatment or services eligible for health insurance coverage shall be subject to peer review procedures. These procedures may be initiated by a health insurer in the course of reviewing claims for payment.

(f) Repealed.

(g) All individual health benefit plans or certificates shall offer coverage for the medical and psychological treatment of drug abuse, alcohol abuse, and mental illness. Coverage shall be offered for at least the minimum levels set forth in §§ 31-3103 and 31-3104.

(h) Group health benefit plans or certificates that are the result of collective bargaining between a legally-certified union and the employer shall be required to include coverage for inpatient and outpatient treatment of drug abuse, alcohol abuse, and mental illness. The minimum levels of coverage set forth in §§ 31-3103 and 31-3104 shall not apply to those group health benefit plans or certificates until 5 years from February 28, 1987, unless the Mayor requests the Council to extend the exemption to a time certain and the Council, by resolution, approves the extension.

(i) If a large group health benefit plan offers a participant or beneficiary 2 or more benefit package options under the plan, the requirements of this chapter shall be applied separately to each option.

(j) A health insurer may require that substance abuse and mental illness insurance coverage shall be provided through a managed care system.

(Feb. 28, 1987, D.C. Law 6-195, § 3, 34 DCR 491; Apr. 30, 1988, D.C. Law 7-104, § 21, 35 DCR 147; Mar. 16, 1993, D.C. Law 9-192, § 2(a), (b), 39 DCR 9007; Mar. 23, 1995, D.C. Law 10-247, § 3, 42 DCR 457; Oct. 21, 2000, D.C. Law 13-178, § 2(b), 47 DCR 6844; Mar. 8, 2007, D.C. Law 16-242, § 2(b), 54 DCR 601; Apr. 24, 2007, D.C. Law 16-305, § 42, 53 DCR 6198.)

Section references. — This section is referred to in §§ 31-3103, 31-3104, and 31-3110.

Prior Codifications. — 1981 Ed., § 35-2302.

Effect of amendments. — D.C. Law 13-178 added subsec. (i).

D.C. Law 16-242 rewrote subsecs. (a) and (b); in subsec. (e), substituted “a health insurer” for

“an insurer”; repealed subsec. (f); in subsec. (g), substituted “health benefit plans or certificates” for “subscriber contracts or policies”; in subsec. (h), substituted “health benefit plans or certificates” for “health insurance policies or contracts”; in subsec. (i), substituted “health benefit plan” for “health plan”; and added subsec. (j).

D.C. Law 16-305, in subsec. (d), substituted “has a drug addiction or an alcohol addiction or a mental illness” for “is suffering from drug abuse, alcohol abuse, or mental illness”.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(b) of Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Temporary Amendment Act of 1998 (D.C. Law 12-108, May 8, 1998, law notification 45 DCR 3259).

Emergency legislation. — For temporary amendment of section, see § 2(b) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Emergency Amendment Act of 1998 (D.C. Act 12-274, February 19, 1998, 45 DCR 1526), and § 2(b) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Second Emergency Amendment Act of 1998 (D.C. Act 12-546, December 18, 1998, 46 DCR 497).

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 7-104. — Law 7-104, the “Technical Amendments Act of 1987,” was introduced in Council and assigned Bill No. 7-346, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on Nov. 24, 1987 and Dec. 8, 1987, respectively. Signed by the Mayor on Dec. 22, 1987, it was assigned Act No. 7-124 and transmitted to both Houses of Congress for its review.

Legislative history of Law 9-192. — Law 9-192, the “Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Amendment Act of 1992,” was introduced in Council and assigned Bill No. 9-310, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 6, 1992, and November 4, 1992, respectively. Signed by the Mayor on November 23, 1992, it was assigned Act No. 9-313 and transmitted to both Houses of Congress for its review. D.C. Law 9-192 became effective on March 16, 1993.

Legislative history of Law 10-247. — For legislative history of D.C. Law 10-247, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 13-178. — For Law 13-178, see notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

Legislative history of Law 16-305. — For Law 16-305, see notes following § 31-1131.11.

§ 31-3103. Drug abuse and alcohol abuse benefits.

(a) Covered benefits for services set forth in this section shall be limited to coverage of treatment of clinically significant substance use disorders identified in the most recent edition of the International Classification of Diseases or of the Diagnostic and Statistical Manual of the American Psychiatric Association.

(b)(1) The process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum, shall be a covered benefit.

(2) Treatment under this subsection shall be covered pursuant to § 31-3102 for a minimum of 12 days annually.

(c)(1) Additional treatment as a covered benefit under this chapter shall be provided by a hospital, a nonhospital residential facility, an outpatient treatment facility, a physician, a psychologist, an advanced practice registered nurse, or a social worker, and shall include inpatient services, outpatient services, or any combination of these, certified as necessary by a physician, psychologist, advanced practice registered nurse, or social worker.

(2) Treatment under this subsection shall be covered pursuant to § 31-3102 for a minimum of 60 days per year for inpatient or residential care in a hospital or nonhospital residential facility and at a minimum rate of 75% for

the first 40 outpatient visits per year and at a minimum rate of 60% for any outpatient visits thereafter for that year.

(d) Treatment regimens which include psychiatric, psychological, and other prescribed interventions shall be a covered benefit.

(e)(1) A group or individual health benefit plan, other than a long-term care policy, disability income policy, or supplemental policy covering a specified disease or other limited benefit unrelated to medical expenses, that is delivered, issued for delivery, or renewed in the District of Columbia shall not exclude the payment of benefits as set forth in the certificate of coverage for illnesses, injuries, or conditions sustained by an insured person because the insured was intoxicated or under the influence of any narcotic. This subsection shall not preclude a health insurer from excluding coverage for an insured individual for any illness, injury, or condition that is the direct result of the commission of a felony by the insured person.

(2) The Mayor may promulgate rules and regulations as are necessary or appropriate to carry out the provisions of this subsection.

(Feb. 28, 1987, D.C. Law 6-195, § 4, 34 DCR 491; Mar. 23, 1995, D.C. Law 10-247, § 3, 42 DCR 457; Mar. 8, 2007, D.C. Law 16-242, § 2(c), 54 DCR 601; Mar. 8, 2007, D.C. Law 16-247, § 3, 54 DCR 620.)

Section references. — This section is referred to in §§ 31-3102, 31-3106, and 31-3110.

Prior Codifications. — 1981 Ed., § 35-2303.

Effect of amendments. — D.C. Law 16-242 rewrote subsec. (c)(2) which had read as follows: “(2) Treatment under this subsection shall be covered pursuant to § 31-3102 for a minimum of 28 days per year for inpatient or residential care in a hospital or nonhospital residential facility, and for a minimum of 30 outpatient visits per year.”

D.C. Law 16-247 added subsec. (e).

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 10-247. — For legislative history of D.C. Law 10-247, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

Legislative history of Law 16-247. — Law 16-247, the “Alcohol and Narcotics-Related Claims Liability Exclusion Repeal Amendment Act of 2006”, was introduced in Council and assigned Bill No. 16-949, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28 2006, it was assigned Act No. 16-603 and transmitted to both Houses of Congress for its review. D.C. Law 16-247 became effective on March

Editor’s notes. — Section 4 of D.C. Law 16-247 provided: “This act shall apply to all individual and group health benefit plans delivered, issued for delivery, or renewed on the first day of the month beginning on or after 90 days after the effective date of this act.”

§ 31-3104. Mental illness benefits.

(a) Covered benefits for services set forth in this section shall be limited to coverage of treatment of clinically significant mental illnesses identified in the most recent edition of the International Classification of Diseases or of the Diagnostic and Statistical Manual of the American Psychiatric Association.

(b) Treatment under this section shall be covered pursuant to § 31-3102 for a minimum of 60 days per year for inpatient or residential care in a hospital or nonhospital residential facility, and at a minimum rate of 75% for the first 40 outpatient visits per year and at a minimum rate of 60% for any outpatient visits thereafter for that year.

(Feb. 28, 1987, D.C. Law 6-195, § 5, 34 DCR 491; Mar. 8, 2007, D.C. Law 16-242, § 2(d), 54 DCR 601.)

Section references. — This section is referred to in §§ 31-3102, 31-3105, 31-3106, and 31-3110.

Prior Codifications. — 1981 Ed., § 35-2304.

Effect of amendments. — D.C. Law 16-242, in subsec. (b), substituted “60 days” for “45 days”.

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

§ 31-3105. Exemptions.

(a) Methods of determining levels of payment or reimbursement for services, or for the type of facility charge eligible for payment or reimbursement under this chapter, and shall be consistent with those for physical illnesses in general and shall take into consideration usual, customary, and reasonable charges for those services. Except as otherwise provided in § 31-3104, deductible or copayment plans, and limits on total amounts payable to an individual in a calendar year or lifetime payment limits, may be applied; provided, that the inpatient and outpatient benefits set forth in § 31-3104 shall be provided for health plans issued in the individual market and small group market with a lifetime payment limit of not less than \$80,000 or 1/3 of the lifetime maximum for physical illness, whichever is greater; provided further, that for health plans issued in the large group market, the inpatient and outpatient benefits set forth in § 31-3104 shall be applied with the same lifetime and annual limits for medical, surgical, and mental benefits.

(b) If the cost of complying with the mental health benefits provisions of subsection (a) of this section for large group markets result in at least a 1% increase in the cost of the plan, the group health plan (or health benefit plan or certificate offered in connection with a group health plan) shall be exempt from complying with those mental health benefits parity provisions.

(c) If a group health plan is exempt from complying with the mental health benefits parity provisions under subsection (b) of this section, it shall comply with the individual and small group market requirements.

(d) Nothing in this section shall be construed as requiring health maintenance organizations to provide a greater level of covered benefits than the level required of health insurers.

(e) Repealed.

(Feb. 28, 1987, D.C. Law 6-195, § 6, 34 DCR 491; Mar. 16, 1993, D.C. Law 9-192, § 2(c), 39 DCR 9007; Oct. 21, 2000, D.C. Law 13-178, § 2(c), 47 DCR 6844; Mar. 8, 2007, D.C. Law 16-232, § 203, 54 DCR 368; Mar. 8, 2007, D.C. Law 16-242, § 2(e), 54 DCR 601.)

Prior Codifications. — 1981 Ed., § 35-2305.

Effect of amendments. — D.C. Law 13-178 rewrote this section.

D.C. Law 16-232, repealed subsec. (e), which formerly read:

“(e) The mental parity provisions in this section shall not apply to benefits for services furnished after September 29, 2001, unless these provisions are re-enacted.”

D.C. Law 16-242, in subsec. (b), substituted “health benefit plan or certificate” for “health

insurance"; and, in subsec. (d), substituted "health insurers" for "insurers".

Temporary Amendment of Section. — For temporary (225 day) repeal of section, see § 2(c) of Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Temporary Amendment Act of 1998 (D.C. Law 12-108, May 8, 1998, law notification 46 DCR 3259).

Temporary Addition of Section. — For temporary (225 day) addition, see § 2(d) of Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Temporary Amendment Act of 1998 (D.C. Law 12-108, May 8, 1998, law notification 46 DCR).

Section 2(d) of D.C. Law 12-108 was amended by D.C. Law 12-264, § 38, April 20, 1999, 46 DCR 2118.

Emergency legislation. — For temporary amendment of section, see §§ 2(c) and (d) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Emergency Amendment Act of 1998 (D.C. Act 12-274, February 19, 1998, 45 DCR 1526).

For temporary repeal of section, see § 2(c) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Second Emergency Amendment Act of 1998 (D.C. Act 12-546, December 24, 1998, 45 DCR 497).

For temporary addition of § 35-2305.1 1981 Ed., see § 2(d) of the Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Second Emergency Amendment Act of 1998 (D.C. Act 12-546, December 18, 1998, 46 DCR 497).

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 9-192. — For legislative history of D.C. Law 9-192, see Historical and Statutory Notes following § 31-3102.

Legislative history of Law 12-103. — For legislative history of D.C. Law 12-103, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 12-264. — Law 12-264, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-804, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 10, 1998, and December 1, 1998, respectively. Signed by the Mayor on January 7, 1999, it was assigned Act No. 12-626 and transmitted to both Houses of Congress for its review. D.C. Law 12-264 became effective on April 20, 1999.

Legislative history of Law 13-178. — For Law 13-178, see notes following § 31-3101.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

Editor's notes. — Because of the prior expiration of certain provisions of this section required by subsection (e) of this section, section 203(a) of D.C. Law 16-232 provided that "subsections (a) through (d) are hereby revived."

§ 31-3106. Certification of nonhospital residential facilities and outpatient treatment facilities.

(a) The Mayor shall certify qualifying nonhospital residential facilities and outpatient treatment facilities in the District in accordance with rules issued pursuant to § 31-3111.

(b) Each certification issued by the Mayor shall state whether the facility is certified as a provider of treatment for drug abuse, alcohol abuse, mental illness, or a combination of these that shall be specified.

(c) To qualify for certification, a nonhospital residential facility or outpatient treatment facility shall demonstrate that:

(1) It offers an organized program for the treatment of drug abuse, alcohol abuse, mental illness, or any combination of these;

(2) It operates under the day-to-day supervision of an individual with demonstrable training and experience in the treatment of drug abuse, alcohol abuse, or mental illness;

(3) It employs sufficient numbers of professional staff members to deliver adequately the services offered to its patient caseload; and

(4) It offers and has the capacity to provide services for the durations specified in §§ 31-3103 and 31-3104.

(d) Nothing in this section shall be construed as superseding the requirements of chapter 5 of Title 44.

(e) Any certification issued pursuant to this section shall be issued as a Public Health: Human Services Facility endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(Feb. 28, 1987, D.C. Law 6-195, § 7, 34 DCR 491; Apr. 20, 1999, D.C. Law 12-261, § 2003(kk), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38, § 3(y), 50 DCR 6913.)

Cross references. — Substance abuse treatment certification requirements, see § 44-1204.

Prior Codifications. — 1981 Ed., § 35-2306.

Effect of amendments. — D.C. Law 15-38, in subsec. (e), substituted “Public Health: Human Services Facility endorsement to a basic business license under the basic” for “Class A Public Health: Human Services Facility endorsement to a master business license under the master”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(y) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 12-261. — Law 12-261, the “Second Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 15-38. — For Law 15-38, see notes following § 31-1103.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 6-195, “Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Act of 1986.”, see Mayor’s Order 88-50, February 25, 1988.

§ 31-3107. Preservation of certain benefits.

Nothing in this chapter shall serve to diminish the benefits of any insured person or prevent the offering or acceptance of benefits that exceed the minimum benefits required by this chapter.

(Feb. 28, 1987, D.C. Law 6-195, § 8, 34 DCR 491.)

Prior Codifications. — 1981 Ed., § 35-2307.

Legislative history of Law 6-195. — For

legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

§ 31-3108. Notification of coverage and benefits.

All individual and group health benefit plans shall contain statements, in easily readable type and in easily understandable language, approved by the Commissioner, to inform policyholders and beneficiaries of the coverage and benefits provided or offered pursuant to this chapter.

(Feb. 28, 1987, D.C. Law 6-195, § 9, 34 DCR 491; May 21, 1997, D.C. Law 11-268, § 10(w), 44 DCR 1730; Mar. 8, 2007, D.C. Law 16-242, § 2(f), 54 DCR 601.)

Section references. — This section is referred to in § 31-3110.

Prior Codifications. — 1981 Ed., § 35-2308.

Effect of amendments. — D.C. Law 16-242 substituted “health benefit plans” for “health insurance policies”.

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see His-

torical and Statutory Notes following § 31-3101.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

§ 31-3109. Filing and rate requirements.

(a)(1) Notwithstanding the provisions of any other law, any health insurer that issues health benefits plan or certificates in the District shall file with the Commissioner all rates and rating plans, rules, and classifications that it proposes to use in providing or offering the coverage required by this chapter.

(2) Each health insurer shall initially file the documents required by this section no later than 120 days after the effective date of rules issued pursuant to § 31-3111 and shall thereafter file any changes in rates and rating plans, rules, and classifications related to the coverage required by this chapter in a timely manner in accordance with rules issued by the Commissioner.

(3) The Commissioner shall make the documents filed pursuant to this section available for public inspection during normal business hours.

(b)(1) The rates and charges filed pursuant to subsection (a) of this section shall be subject to review by the Commissioner for a period of 90 calendar days from the date of filing. If after 90 days the Commissioner has not made a final determination on the final rates or charges proposed, the health insurer may begin charging the proposed rate. The rates and charges shall remain in effect unless and until, in accordance with the provisions of this section, changed by the health insurer or disapproved by the Commissioner.

(2) Except as otherwise provided in § 31-3110(d)(2), rates and charges for the coverage required by this chapter shall not be excessive and shall be reasonably related to the cost of providing the coverage based on the following factors:

(A) Past and prospective experience within the covered group, or within the geographic region of the District or other regions, concerning the proportion of beneficiaries who use the coverage and the average duration of use;

(B) Usual, customary, and reasonable charges by providers of treatment for drug abuse, alcohol abuse, and mental illness within the District or other regions; and

(C) Past and prospective experience within the covered group, or within the geographic region of the District or other regions, concerning claims filed or services required for physical diseases and disorders by beneficiaries who obtain treatment for drug abuse, alcohol abuse, or mental illness or whose household includes an individual who has obtained treatment for drug abuse, alcohol abuse, or mental illness.

(3) Rates and charges for the coverage required by this chapter may include a reasonable margin for underwriting profit and contingencies.

(c)(1) The Commissioner shall review all rates and rating plans, rules, and classifications filed pursuant to this section to determine compliance with this chapter.

(2) The Commissioner may, following a hearing pursuant to § 2-509, order adjustments in rates and rating plans, rules, and classifications that the Commissioner determines to be excessive or otherwise not in compliance with this chapter. The Commissioner may order the insurer to refund to its policyholders a sum equal to the amount of the rate or charge determined to be excessive.

(d) Nothing in this section shall be construed to require uniformity in rates, classifications, rating plans, or charges.

(Feb. 28, 1987, D.C. Law 6-195, § 10, 34 DCR 491; May 21, 1997, D.C. Law 11-268, § 10(w), 44 DCR 1730; Mar. 8, 2007, D.C. Law 16-242, § 2(g), 54 DCR 601.)

Section references. — This section is referred to in § 31-3110.

Prior Codifications. — 1981 Ed., § 35-2309.

Effect of amendments. — D.C. Law 16-242, in subsecs. (a)(1), (a)(2), and (b)(1), substituted “health insurer” for “insurer”; and, in subsec. (a)(1), substituted “health benefits plan or certificates” for “health insurance policies or contracts”.

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see His-

torical and Statutory Notes following § 31-3101.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-3101.

§ 31-3110. Health maintenance organizations.

(a) The requirements of this chapter shall apply to health maintenance organizations 5 years from February 28, 1987, unless the Mayor requests the Council to extend the exemption to a time certain and the Council, by resolution, approves the extension.

(b) Upon becoming subject to the requirements of this chapter, each health maintenance organization shall:

(1) Provide to its members the coverage and benefits required by §§ 31-3102, 31-3103, and 31-3104;

(2) Ensure that deductible or copayment plans, durational limits, and methods of determination adopted with respect to coverage of the benefits required by §§ 31-3102, 31-3103, and 31-3104 result in coverage that is determined by the Commissioner to be at least equivalent in actuarial value to the average actuarial value of the plans provided by the health insurer with the largest number of enrollees in the District; and

(3) Provide the notification of coverage and benefits required by § 31-3108.

(c) Each health maintenance organization may provide the treatment required by §§ 31-3103 and 31-3104 directly by its staff or by referring its members to a hospital or other treatment facility that provides those services under a contract or agreement with the health maintenance organization. Nothing in this chapter shall require the alteration of any terms and conditions of the health maintenance organization membership contract relating to prior approval by the health maintenance organization for treatment provided to its members by other treatment facilities.

(d)(1) Each health maintenance organization, within 120 days after becoming subject to the requirements of this chapter, shall file with the Commissioner the membership contracts it proposes to use, identifying its charges for all services and the portion of charges attributable to the services required by this chapter.

(2) The provisions of § 31-3109, except for subsection (b)(2) of this section, shall apply thereafter to the membership contracts and charges filed and implemented by health maintenance organizations. Rates and charges for the coverage required by this chapter shall not be excessive and shall be reasonably related to the cost of providing the coverage.

(Feb. 28, 1987, D.C. Law 6-195, § 11, 34 DCR 491; May 21, 1997, D.C. Law 11-268, § 10(w), 44 DCR 1730; Mar. 8, 2007, D.C. Law 16-242, § 2(h), 54 DCR 601.)

Section references. — This section is referred to in §§ 31-3101, 31-3109, and 31-3111.

Prior Codifications. — 1981 Ed., § 35-2310.

Effect of amendments. — D.C. Law 16-242, in subsec. (b)(2), substituted “health insurer” for “insurer”.

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see His-

torical and Statutory Notes following § 31-3101.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

§ 31-3111. Duties of Mayor.

(a) The Mayor shall, within 120 days from February 28, 1987, issue rules to implement all sections of this chapter except § 31-3110. The Mayor shall issue rules to implement § 31-3110 no later than 5 years from February 28, 1987.

(b) The Mayor shall provide the coverage and benefits set forth in this chapter to employees of the District and their dependents who are insured through the District of Columbia Employees’ Health Benefits Program. For District employees and their dependents who are insured through the Federal Employees’ Health Benefits Program, the Mayor shall provide supplemental coverage and benefits that comply with the requirements of this chapter no later than February 28, 1994.

(Feb. 28, 1987, D.C. Law 6-195, § 12, 34 DCR 491; Mar. 16, 1993, D.C. Law 9-192, § 2(d), 39 DCR 9007.)

Section references. — This section is referred to in §§ 31-3106 and 31-3109.

Prior Codifications. — 1981 Ed., § 35-2311.

Legislative history of Law 6-195. — For legislative history of D.C. Law 6-195, see Historical and Statutory Notes following § 31-3101.

Legislative history of Law 9-192. — For

legislative history of D.C. Law 9-192, see Historical and Statutory Notes following § 31-3102.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 6-195, “Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Act of 1986.”, see Mayor’s Order 88-50, February 25, 1988.

§ 31-3112. Excluded programs.

This chapter shall not be applicable to the District of Columbia Alliance

Program, Medicaid Program, and Post-1987 District of Columbia Employees' Health Insurance Benefits Plan.

(Feb. 28, 1987, D.C. Law 6-195, § 12a, as added Mar. 8, 2007, D.C. Law 16-242, § 2(i), 54 DCR 601.)

Legislative history of Law 16-242. — For Law 16-242, see notes following § 31-3101.

Editor's notes. — Section 3 of D.C. Law 16-242 provided: "Section 2 shall apply to all

individual and group health benefit plans issued or renewed on the first day of the month beginning on or after 90 days after the effective date of this act."

CHAPTER 31A. HEALTH BENEFIT PLANS PROMPT PAYMENT.

Sec.

31-3131. Definitions.

31-3132. Prompt payment.

31-3133. Retroactive denial of reimbursement.

31-3134. Provider panels.

Sec.

31-3135. Claims payment report.

31-3136. Penalties.

31-3137. Rules and regulations.

31-3138. Applicability.

§ 31-3131. Definitions.

For the purposes of this chapter, the term:

(1) “Clean claim” means a claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation, which substantially prevents timely payment from being made on the claim or with respect to a health insurer that has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with § 31-3132. For the purposes of this paragraph, the term “material defect” means an imperfection in the submission of a claim consisting in the omission of information that is essential to process the claim in accordance with the health plan’s published claim filing requirements. The requirements for electronic claim submissions shall be consistent with regulations promulgated by Secretary of Health and Human Services pursuant to section 1173 of the Social Security Act, approved August 14, 1935 (110 Stat. 2024; 42 U.S.C. § 1320d-2).

(2) “Coding guidelines” means those standards or procedures used or applied by a payor to determine the most accurate and appropriate code or codes for payment by the payor for a service.

(3) “Commissioner” means the Commissioner of the Department of Insurance and Securities Regulation.

(4) “Health benefits plan” means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term “health benefit plan” does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) “Health insurer” means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Person" means an enrollee or subscriber in a health benefit plan, provider, or physician.

(7) "Provider" means a health care practitioner, group of health care practitioners, or other entity licensed, certified, or otherwise authorized by law to provide hospital, physician, or other health care services.

(8) "Provider panel" means the providers that contract either directly, or through a subcontracting entity, with a health insurer to provide health care services to the health insurer's enrollees under the health insurer's health benefit plan. The term "provider panel" shall not include an arrangement in which any provider may participate solely by contracting with the health insurer to provide health care services at a discounted fee-for-service rate.

(July 23, 2002, D.C. Law 14-176, § 2, 49 DCR 5086.)

Legislative history of Law 14-176. — Law 14-176, the "Prompt Pay Act of 2002", was introduced in Council and assigned Bill No. 14-166, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on

April 9, 2002, and May 7, 2002, respectively. Signed by the Mayor on May 20, 2002, it was assigned Act No. 14-369 and transmitted to both Houses of Congress for its review. D.C. Law 14-176 became effective on July 23, 2002.

§ 31-3132. Prompt payment.

(a) For covered services rendered to its members, a health insurer shall reimburse any person entitled to reimbursement under the health benefits plan within 30 days after the receipt of a clean claim.

(b) If a health insurer fails to comply with subsection (a) of this section, the health insurer shall pay interest beginning on the 31st day after the receipt of the claim if the claim remains unpaid after 30 days. A formal claim by the person filing the original claim shall not be required.

(c) The interest payable shall be at a monthly rate of:

- (1) One and one-half percent from the 31st day through the 60th day;
- (2) Two percent from the 61st day through the 120th day; and
- (3) Two and one-half percent after the 120th day.

(d) This section shall not apply to claims if the health insurer:

(1) Notifies the person submitting the claim within 30 days after the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute;

(2) States, in writing, to the person the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute; and

(3) Pays any undisputed portion of the claim within 30 days of the receipt of the claim.

(e) The health insurer shall process the disputed portion of the claim within 30 days after receipt of all reasonable and necessary documentation.

(f) If a health insurer fails to comply with the requirements of subsection (e) of this section, it shall pay interest at the rates set forth in subsection (c) of this section beginning on the 31st day after the filing of the receipt of the documentation as provided in subsection (e) of this section.

(g) A health insurer shall allow a provider a minimum of 180 days from the

date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement for the service.

(h) There shall be a rebuttable presumption that a claim has been received by a health insurer:

(1) Within 5 business days from the date the provider or person entitled to reimbursement placed the claim in the United States mail;

(2) Within 24 hours if the claim was submitted by the provider or provider's agent electronically and was not returned to the provider by a claims clearinghouse or returned to the provider by the insurer if submitted directly to the health insurer; or

(3) On the date recorded by the courier if the claim was delivered by courier.

(i) Each health insurer shall provide a manual or other document that sets forth the claims submission procedures to all contracting providers at the time of contracting and 30 days prior to any changes in the procedure.

(j) A health insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including electronic or facsimile confirmation of receipt of a claim.

(k) A health insurer shall not be in violation of this chapter if its failure to pay a claim in accordance with the time periods provided in this chapter is caused:

(1) In material part by the person submitting the claim; or

(2) By impossibility due to matters beyond the health insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages.

(l) This section shall not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health insurer's obligation on such claims.

(July 23, 2002, D.C. Law 14-176, § 3, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3133. Retroactive denial of reimbursement.

(a) A health insurer may only retroactively deny reimbursement to a health care provider:

(1) For services subject to coordination of benefits with another health insurer during the 18-month period after the date that the health insurer paid the health care provider; or

(2) Except as provided in paragraph (1) of this subsection, during the 6-month period after the date that the health insurer paid the health care provider.

(b)(1) A health insurer that retroactively denies reimbursement to a health care provider under subsection (a)(1) of this section shall provide the health care provider with a written statement specifying the basis for the retroactive

denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(2) This subsection shall not apply if a health insurer retroactively denies reimbursement to a health care provider because:

(A) The information submitted to the health insurer was fraudulent;

(B) The information submitted to the health insurer was improperly coded and the health insurer has provided to the health care provider sufficient information regarding the coding guidelines used by the health insurer at least 30 days prior to the date the services subject to the retroactive denial were rendered; or

(C) The claim submitted to the health insurer was a duplicate claim.

(3) Information submitted to the health insurer may be considered to be improperly coded under paragraph (1) of this subsection if the information submitted to the health insurer by the health care provider:

(A) Uses codes that do not conform with the coding guidelines used by the health insurer applicable as of the date that services were rendered; or

(B) Does not otherwise conform with the contractual obligations of the health care provider to the health insurer applicable as of the date that services were rendered.

(c) If a health insurer retroactively denies reimbursement for services as a result of coordination of benefits, the health care provider shall have 180 days after the date of denial, unless the health insurer permits a longer time period, to submit a claim for reimbursement for the service to the health insurer responsible for payment.

(d) A health insurer that retroactively denies reimbursement to a health care provider under this section shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(e) This section shall not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk-sharing arrangement.

(July 23, 2002, D.C. Law 14-176, § 4, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3134. Provider panels.

(a) Except for Medicaid and Medicare provider panels, if a provider panel contract between a provider and a health insurer, or other entity that provides hospital, physician, or other health care services to a health insurer, require a provider, as a condition of participating in one of the health insurer's or other entity's provider panels, to participate in any other provider panel owned or operated by the health insurer or other entity, the contract shall contain a provision permitting the provider to refuse participation in one or more of the other provider panels at the time the contract is executed or renewed. The status of a physician as a member of, or as being eligible for, other existing or new provider panels shall not be adversely affected by the exercise of the right to refuse participation.

(b) If a provider elects to terminate participation on a provider panel of a health insurer or entity that provides hospital, physicians, or health services to a health insurer, the provider shall:

(1) Notify the health insurer at least 90 days before termination; and

(2) For at least 90 days after the date of notice of termination, continue to furnish health care services to an enrollee of a health insurer for whom the provider was responsible for the delivery of health care services prior to the notice of termination.

(July 23, 2002, D.C. Law 14-176, § 5, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3135. Claims payment report.

A health insurer shall include with its annual report filed with the Commissioner a claims payment report to include the:

(1) Number of claims received in the previous calendar year;

(2) Number of claims denied in the previous calendar year;

(3) Number of claims paid:

(A) In the previous calendar year;

(B) In 30 days;

(C) In 60 days;

(D) In 120 days; and

(E) In more than 120 days; and

(4) Average number of days to pay a claim submitted in the previous calendar year.

(July 23, 2002, D.C. Law 14-176, § 6, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3136. Penalties.

An action by a health insurer that establishes a pattern or practice of repeated violation of this chapter, as determined by the Commissioner, shall constitute a violation as provided in Chapter 22A of this title.

(July 23, 2002, D.C. Law 14-176, § 7, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3137. Rules and regulations.

The Commissioner may adopt rules and regulations as necessary to implement this chapter.

(July 23, 2002, D.C. Law 14-176, § 8, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

§ 31-3138. Applicability.

(a) This chapter shall apply to any individual and group health benefits plan issued or renewed in the District of Columbia. Health insurers shall comply with this chapter on the earlier of October 16, 2002, or the effective date of the claims payment standards in section 1173 of the Social Security Act, approved August 14, 1935 (110 Stat. 2024; 42 U.S.C. § 1320d-2).

(b) Section 31-3132 shall apply to claims received on or after October 16, 2002.

(c) Section 31-3133 shall apply to retroactive denials made on or after October 16, 2002.

(d) Section 31-3134 shall apply to any contract issued or renewed on or after October 16, 2002.

(e) Section 31-3135 shall apply to claims data collected beginning with the first full calendar year following July 23, 2002. A health insurer shall include this data in the annual report filed with the Commissioner beginning on March 15, 2004.

(July 23, 2002, D.C. Law 14-176, § 9, 49 DCR 5086.)

Legislative history of Law 14-176. — For Law 14-176, see notes following § 31-331.

CHAPTER 31B. HEALTH BENEFIT PLANS WITHDRAWAL FROM MARKET.

Sec.

31-3151. Definitions.

31-3152. Procedures for voluntary withdrawal
by carriers.

Sec.

31-3153. Judicial review; mandamus.

31-3154. Regulations.

§ 31-3151. Definitions.

For the purposes of this chapter, the term:

(1) “Application” means a carrier’s application pursuant to this chapter for approval to voluntarily withdraw from the District of Columbia health insurance market.

(2) “Carrier” means any person or organization subject to the authority of the Commissioner that provides one or more health benefit plans in the District of Columbia, and includes an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, or multiple employer welfare arrangement.

(3) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(4) “Health benefit plan” means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, a plan provided by a multiple employer welfare arrangement, or a plan provided by another benefit arrangement. The term “health benefit plan” does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers’ compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; scattered sections of the United States Code).

(6) “Medicare” means the health insurance program established pursuant to the Health Insurance for the Aged Act, approved July 30, 1965 (79 Stat. 290; 42 U.S.C. § 401 et seq.).

(7) “Withdraw” means the full cessation of underwriting insurance policies, including the nonrenewal of existing insurance policies, relative to any line of business or any subgroup thereof, including individual accounts.

(Apr. 12, 2005, D.C. Law 15-328, § 2, 52 DCR 1459.)

Legislative history of Law 15-328. — Law 15-328, the “Procedures for the Voluntary Withdrawal from the Market by Carriers Licensed

in the District of Columbia to Sell Health Benefit Plans Act of 2004”, was introduced in Council and assigned Bill No. 15-876, which

was referred to the Committee on Consumers and Regulatory Affairs. The Bill was adopted on first and second readings on November 9, 2004, and December 7, 2004, respectively.

Signed by the Mayor on December 29, 2004, it was assigned Act No. 15-687 and transmitted to both Houses of Congress for its review. D.C. Law 15-328 became effective on April 12, 2005.

§ 31-3152. Procedures for voluntary withdrawal by carriers.

(a) A carrier shall give the Commissioner written notice, prior to notifying the members of the health benefit plan, of its intent to discontinue the offering of all health benefit plans in the District of Columbia and shall submit to the Commissioner an application with the following information:

- (1) The name of the carrier;
- (2) The name, address, telephone number, and facsimile number of the carrier's representative responsible for the activities pertaining to withdrawing from the District of Columbia health insurance market;
- (3) A specific description of the reasons the carrier is withdrawing its health benefit plans from the District of Columbia health insurance market;
- (4) A statement of the number of in-force policies affected by the withdrawal;
- (5) A copy of the nonrenewal notice, which complies with HIPAA, that the carrier will send to its enrollees and dependents once its application is approved; and

(6) Any other information or documentation that the Commissioner considers relevant and appropriate in connection with the carrier ceasing to offer a health benefit plan in the District of Columbia.

(b) The carrier shall obtain prior approval of its application from the Commissioner before it commences to voluntarily withdraw from the District of Columbia health insurance market.

(c) The Commissioner shall complete his or her review of the application submitted by the carrier to withdraw from the District of Columbia health insurance market within 60 days after receipt of all requested documentation.

(d) To ensure that health care services will be available and accessible to all group and nongroup policyholders of a withdrawing carrier, the Commissioner may allocate the group and nongroup contracts among other carriers in a similar manner as provided in § 31-3414.

(e) The Commissioner may condition his or her approval of the carrier's application upon the terms and conditions as are necessary for the protection of the carrier's policyholders, its creditors, or the public interest.

(Apr. 12, 2005, D.C. Law 15-328, § 3, 52 DCR 1459.)

Legislative history of Law 15-328. — For Law 15-328, see notes following § 31-3151.

§ 31-3153. Judicial review; mandamus.

(a) Any carrier aggrieved by any act, determination, rule, regulation, or order or any other action of the Commissioner pursuant to this chapter, and

which was the subject of a contested case, may appeal to the District of Columbia Court of Appeals, in accordance with § 2-510.

(b) The filing of an appeal pursuant to this section shall not stay the application of any rule, regulation, order, or other action of the Commissioner to the appealing party unless the court, after giving the appealing party notice and an opportunity to be heard, determines that failure to grant the stay would be detrimental to the interest of policyholders, shareholders, creditors, or the public.

(c) Any carrier aggrieved by any failure of the Commissioner to act or make a determination required by this chapter may petition the Superior Court of the District of Columbia for a writ in the nature of a mandamus or a peremptory mandamus directing the Commissioner to act or make the determination forthwith.

(Apr. 12, 2005, D.C. Law 15-328, § 4, 52 DCR 1459.)

Legislative history of Law 15-328. — For Law 15-328, see notes following § 31-3151.

§ 31-3154. Regulations.

The Commissioner may promulgate rules and regulations necessary to implement the provisions of this chapter, including provisions for the disposal of books of business.

(Apr. 12, 2005, D.C. Law 15-328, § 5, 52 DCR 1459.)

Legislative history of Law 15-328. — For Law 15-328, see notes following § 31-3151.

CHAPTER 31C. HEALTH BENEFIT PLANS EQUITY.

Sec.

31-3161. Prohibition on gender-based discrimination in rate making.

Sec.

31-3162. Rules.

31-3163. Application.

§ 31-3161. Prohibition on gender-based discrimination in rate making.

(a) For the purposes of this section, the term “health benefit plan” shall have the same meaning as provided in § 31-3001(1).

(b) An individual health benefit plan offered, sold, issued, or renewed to a District resident shall not have a premium rate, or any other underwriting decision, determined through a method that is in any way based upon the gender or sex of a person covered under the health benefit plan.

(c) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide hospitalization benefits for childbirth to the same extent as benefits provided in the policy for any covered illness. In addition to the provisions of this subsection and subsection (c) of this section, if a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the individual health benefit plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.

(d) Each individual health benefit plan offered, sold, issued, or renewed in the District shall provide coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of:

(1) Forty-eight hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and

(2) Ninety-six hours of inpatient hospitalization care after an uncomplicated cesarean section.

(e) A mother may request a shorter length of stay than that provided in subsection (c) of this section if the mother decides, in consultation with the mother’s attending provider, that less time is needed for recovery.

(f)(1) For a mother and newborn child who have a shorter hospital stay than that provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for:

(A) One home visit scheduled to occur within 24 hours after hospital discharge; and

(B) An additional home visit if prescribed by the mother’s attending provider.

(2) For a mother and newborn child who remain in the hospital for at least the length of time provided under subsection (c) of this section, the individual health benefit plan shall provide coverage for a home visit if prescribed by the mother’s attending provider.

(3) A home visit under paragraph (1) or (2) of this subsection shall:

(A) Be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;

(B) Be provided by a registered nurse with at least one year of

experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

(C) Include any services required by the mother's attending provider.

(Apr. 8, 2011, D.C. Law 18-360, § 302, 58 DCR 896.)

Legislative history of Law 18-360. — Law 18-360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18-792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and

second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18-710 and transmitted to both Houses of Congress for its review. D.C. Law 18-360 became effective on April 8, 2011.

§ 31-3162. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18-360, § 303, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3161.

§ 31-3163. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31-3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18-360, § 304, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3161.

CHAPTER 31D. HEALTH BENEFIT EXCHANGE.

Sec.	Sec.
31-3171.01. Definitions.	31-3171.09. Health benefit plan certification.
31-3171.02. Establishment and purpose.	31-3171.10. Conflicts of interest.
31-3171.03. District of Columbia Health Benefit Exchange Authority Fund.	31-3171.11. Open meetings.
31-3171.04. Authority duties and powers.	31-3171.12. Limitation of liability.
31-3171.05. Executive board establishment and membership.	31-3171.13. Relation to other laws.
31-3171.06. Powers and duties of executive board.	31-3171.14. Powers of the Mayor.
31-3171.07. Advisory board.	31-3171.15. Dissolution of the Authority.
31-3171.08. Executive director and Authority staff.	31-3171.16. Implementation and reports.
	31-3171.17. Rules.
	31-3171.18. Applicability.

§ 31-3171.01. Definitions.

For the purposes of this chapter, the term:

(1) "American Health Benefit Exchange" means an entity established pursuant to § 31-3171.04, and section 1311(b) of the Federal Act.

(2) "Authority" means the District of Columbia Health Benefit Exchange Authority established by § 31-3171.02.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities and Banking, as established by § 31-102.

(4) "Federal Act" means the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001, note), as amended by the Health Care and Education Reconciliation Act of 2010 approved March 30, 2010 (124 Stat. 1029; 42 U.S.C. § 1305, note), and any amendments, regulations, or guidance issued pursuant to the Federal Act.

(5)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(B) The term "health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Liability insurance, including general liability insurance and automobile liability insurance;

(iii) Coverage issued as a supplement to liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. § 201, note) ("HIPAA"), under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance, or are otherwise not an integral part of the plan:

- (i) Limited scope dental or vision benefits;
- (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
- (iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(D) The term “health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance, and there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

- (i) Coverage only for a specified disease or illness; or
- (ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term “health benefit plan” does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

- (i) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));
- (ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; or
- (iii) Similar supplemental coverage provided to coverage under a group health plan.

(6) “Health carrier” means an entity subject to the insurance laws and regulations of the District that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including:

- (A) An accident and sickness insurance company;
- (B) A health maintenance organization;
- (C) A hospital and medical services corporation; or
- (D) Any other entity providing a health benefit plan.

(7) “Health professional” shall have the same meaning as provided in § 3-1201.01(8).

(8) “Internal Revenue Code of 1986” means the Internal Revenue Code of 1986, approved August 16, 1954 (100 Stat. 2095; 26 U.S.C. § 1 et seq.).

(9) “PHSA” means the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. § 201 et seq.).

(10) “Qualified dental plan” means a limited-scope dental plan that has been certified in accordance with § 31-3171.09.

(11) “Qualified employer” means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the Small Business Health Options Program Exchange (“SHOP Exchange”), and, at the option of the employer, some or all of its part-time employees; provided, that the employer:

(A) Has its principal place of business in the District and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the District.

(12) “Qualified health plan” means a health benefit plan that has a certification validating that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and § 31-3171.09.

(13) “Qualified individual” means an individual, including a minor, who:

(A) Is seeking to enroll in a qualified health plan offered to individuals through the Authority;

(B) Resides in the District;

(C) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(D) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(14) “Secretary” means the Secretary of the United States Department of Health and Human Services.

(15) “SHOP Exchange” means a Small Business Health Options Program Exchange established pursuant to § 31-3171.04, and section 1311(b) of the Federal Act.

(16)(A) “Small employer” means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

(B) For the purposes of this paragraph:

(i) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986 (26 U.S.C. § 414(b), (c), (m), or (o)) shall be treated as a single employer.

(ii) An employer and any predecessor employer shall be treated as a single employer.

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for health benefit coverage through the employer.

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that employer is reasonably expected to employ in the current calendar year.

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

(17) “Social Security Act” means the Social Security Act, approved August 14, 1935 (49 Stat. 620; 42 U.S.C. § 301 et seq.), as amended.

(Mar. 2, 2012, D.C. Law 19-94, § 2, 59 DCR 213.)

Legislative history of Law 19-94. — Law 19-94, the “Health Benefit Exchange Authority Establishment Act of 2011”, was introduced in Council and assigned Bill No. 19-2, which was

referred to the Committee on Health, Public Services and Consumer Affairs. The Bill was adopted on first and second readings on December 2, 2012, and December 20, 2012, respec-

tively. Signed by the Mayor on January 17, 2012, it was assigned Act No. 19-269 and transmitted to both Houses of Congress for its review. D.C. Law 19-94 became effective on March 2, 2012.

§ 31-3171.02. Establishment and purpose.

(a) There is established, as an independent authority of the District government, the District of Columbia Health Benefit Exchange Authority. The Authority shall be an instrumentality, created to effectuate the purposes stated in this chapter, that shall have a legal existence separate from the District government.

(b) The purposes of the Authority shall be to:

- (1) Enable individuals and small employers to find affordable and easier-to-understand health insurance;
- (2) Facilitate the purchase and sale of qualified health plans;
- (3) Assist small employers in facilitating the enrollment of their employees in qualified health plans;
- (4) Reduce the number of uninsured;
- (5) Provide a transparent marketplace for health benefit plans;
- (6) Educate consumers; and
- (7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions.

(Mar. 2, 2012, D.C. Law 19-94, § 3, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.03. District of Columbia Health Benefit Exchange Authority Fund.

(a) There is established as a nonlapsing fund the District of Columbia Health Benefit Exchange Authority Fund ("Fund"), which shall be administered by the Authority in accordance with generally accepted accounting principles and which shall be used solely for the purposes set forth in this chapter and the costs of administering this chapter.

(b) The Fund shall consist of:

- (1) Any user fees, licensing fees, or other assessments collected by the Authority;
- (2) Income from investments made on behalf of the Fund;
- (3) Interest on money in the Fund;
- (4) Money collected by the executive board as a result of a legal or other action;
- (5) Donations;
- (6) Grants;
- (7) All general revenue funds appropriated by a line item in the budget submitted pursuant to § 1-204.46, and authorized by Congress for the purposes of the Authority; and

(8) Any other money from any other source accepted for the benefit of the Fund.

(c) All revenues, income from investments, proceeds, and other monies, from whatever source derived, that are collected or received by the Authority shall be deposited into the Fund. All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available for the uses and purposes set forth in this chapter without regard to fiscal year limitation, subject to authorization by Congress.

(d) The Chief Financial Officer shall invest the money of the Fund in the same manner as other District money may be invested.

(e)(1) The Authority is authorized to charge, through rulemaking:

(A) User fees;

(B) Licensing fees; and

(C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges.

(2) User fees, licensing fees, or other assessments authorized shall not exceed reasonable projections regarding the amount necessary to support the operations of the Authority.

(Mar. 2, 2012, D.C. Law 19-94, § 4, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.04. Authority duties and powers.

(a) The Authority shall:

(1) Establish the American Health Benefit Exchange to assist qualified individuals in the District with enrollment in qualified health plans;

(2) Establish a SHOP Exchange through which qualified employers may access coverage for their employees and shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

(3) Certify plans as qualified health plans as set forth in § 31-3171.09 and make such plans available to qualified individuals and qualified employers, as required by the Federal Act, with effective dates on January 1, 2014; provided, that the Authority shall not make available any health benefit plan that is not a qualified health plan.

(4) Have independent personnel authority to hire, retain, and terminate personnel as appropriate to perform the functions of the Authority consistent with Chapter 6 of Title 1 [§ 1-601.01 et seq.], including establishing compensation and reimbursement consistent with the District's wage grade and non-wage grade schedules;

(5) Have procurement authority independent of the Office of Contracting

and Procurement, consistent with Chapter 3A of Title 2 [§ 2-352.01 et seq.]; except, that § 2-352.02(a), (b), (c), and (e) shall apply.

(6) Publish the average costs of licensing, regulatory fees, and any other payments required by the Authority, and the administrative costs of the Authority, on a website that is publically accessible, to educate consumers on these costs. This information shall include information on monies lost to waste, fraud, and abuse;

(7) Implement procedures for certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and of this chapter, of health benefit plans as qualified health plans;

(8) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, utilizing staff who are trained to provide assistance in a culturally and linguistically appropriate manner;

(9) Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

(10) Maintain a publically accessible website, through which enrollees and prospective enrollees of qualified health plans and dental plans may obtain standardized comparative information, including on health plan quality and performance, for such plans;

(11) Assign a rating to each qualified health plan offered through the exchanges in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

(12) Use a standardized format for presenting health benefit options in the exchanges, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

(13) Conduct eligibility determinations, in accordance with section 1413 of the Federal Act for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any other applicable District program pursuant to the policies and procedures established by the Department of Health Care Finance;

(14) Establish and make available, through a website that is publicly available, a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act, and, if feasible, which is designed to provide consumers with information on out-of-pocket costs for in-network and out-of-network services, taking into account any cost-sharing reductions;

(15) Grant a certification, subject to section 1411 of the Federal Act, attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(A) There is no affordable qualified health plan available through the exchanges, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for another exemption from the individual responsibility requirement or penalty;

(16) Transfer to the Secretary of the United States Department of the Treasury the following:

(A) A list of the individuals who are issued a certification under paragraph (15) of this subsection, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because the employer:

(i) Did not provide minimum essential coverage; or

(ii) Provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or did not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(17) Provide to each employer the name of each employee of the employer described in paragraph (16)(B) of this subsection who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform the duties required of the Authority by the Secretary, or the Secretary of the United States Department of the Treasury, related to determining eligibility for:

(A) Premium tax credits;

(B) Reduced cost-sharing; or

(C) Individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans and qualified dental plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and qualified dental plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(C) Facilitate enrollment in qualified health plans and qualified dental plans;

(D) Provide referrals to an office of health insurance consumer assistance or health insurance ombudsman, including the Office of Health Care Ombudsman and Bill of Rights, or any other appropriate District agency, for any enrollee with a grievance or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchanges;

(20) Review the rate of premium growth within and outside the exchanges and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Consult with stakeholders relevant to carrying out the activities required under this chapter, including:

(A) Educated health care consumers who are enrollees in qualified health plans or qualified dental plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans or dental plans;

(C) Representatives of small businesses and self-employed individuals;

(D) The Department of Health Care Finance;

(E) Individuals who have experience enrolling difficult-to-reach populations in public insurance programs;

(F) Public health experts;

(G) Health care providers; and

(H) Office of Health Care Ombudsman and Bill of Rights;

(22) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, Mayor, Council, and the Commissioner a report of the accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act;

(C) Allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the Authority;

(ii) Examine the properties and records of the Authority; and

(iii) Require periodic reports in relation to the activities undertaken by the Authority; and

(D) In carrying out its activities under this chapter, not use any funds intended for the administrative and operational expenses of the Authority for:

(i) Staff retreats;

(ii) Promotional giveaways;

(iii) Excessive executive compensation; or

(iv) Promotion of federal or District legislative and regulatory modifications not contemplated under the Federal Act.

(b) In addition to certifying qualified health plans, the Authority shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchanges, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

(c) Neither the Authority nor a health carrier offering qualified health plans through the exchanges may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become unaffordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

(d) The operations of the Authority are subject to the provisions of this chapter whether the operations are performed directly by the Authority or through an entity under a contract with the Authority.

(Mar. 2, 2012, D.C. Law 19-94, § 5, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.05. Executive board establishment and membership.

(a) There is established an executive board to govern the Authority consisting of:

(1) Seven voting members, who shall be residents of the District of Columbia, appointed by the Mayor, with the advice and consent of the Council pursuant to § 1-523.01(f).

(2) Four nonvoting, ex-officio members, or their designees, who shall be the:

(A) Director of the Department of Health Care Finance;

(B) Commissioner of the Department of Insurance, Securities and Banking;

(C) Director of the Department of Health; and

(D) Director of the Department of Human Services.

(b)(1) Members of the executive board, other than an ex-officio member, shall be appointed for a term of 4 years, except that for the initial appointments:

(A) Two shall be for a term of 2 years;

(B) One shall be for a term of 3 years;

(C) Two shall be for a term of 4 years; and

(D) Two shall be for a term of 5 years.

(2)(A) A member of the executive board may continue to serve until his or her successor has been approved by the Council and appointed by the Mayor.

(B) Vacancies shall be filled by Mayoral appointment for the unexpired term in the same manner of the original appointment.

(C) A member of the executive board, upon findings by the Mayor, may be removed for incompetence, misconduct, or failure to perform the duties of the position.

(c)(1) Each person appointed to the executive board as a voting member shall have demonstrated and acknowledged expertise in at least 2 of the following areas:

(A) Individual or small employer health care coverage;

(B) Health benefits plan administration;

(C) Health care finance;

(D) Administering a public or private health care delivery system;

(E) Purchasing health plan coverage;

(F) Prior experience in commercial insurance management;

(G) Actuarial analysis;

- (H) Health care economics;
- (I) Human services administration;
- (J) Health care consumer interest advocacy;
- (K) Public health programs; or
- (L) Enrolling individuals into health benefit plans.

(2) The Mayor shall consider the expertise of each of the members of the executive board and attempt to make appointments so that the executive board's composition reflects a diversity of expertise.

(3) At least one voting member of the executive board shall have demonstrated knowledge in health care consumer interest advocacy.

(d) Each member of the executive board shall have the responsibility and duty to meet the requirements of this chapter, the Federal Act, and all applicable District and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the exchanges, and to ensure the operational effectiveness and fiscal solvency of the Authority.

(e) The executive board shall elect a chairperson on an annual basis.

(f) Executive board members shall receive no compensation for their services but shall receive actual and necessary expenses incurred in the performance of their official duties.

(g) The Mayor shall nominate a majority of the executive board members within 90 days of March 2, 2012.

(Mar. 2, 2012, D.C. Law 19-94, § 6, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.06. Powers and duties of executive board.

(a) Subject to any limitations under this chapter, or other applicable law, the executive board shall have all the powers necessary to carry out the functions authorized by the Federal Act and consistent with the purposes of the Authority.

(b) The enumeration of specific powers in this chapter is not intended to restrict the executive board's power to take any lawful action that it determines is necessary to carry out the functions authorized by the Federal Act and is consistent with the purposes of the Authority.

(c) In addition to the powers set forth elsewhere in this chapter, the executive board may:

- (1) Adopt and alter an official seal;
- (2) Sue, be sued, plead, and be impleaded;
- (3) Adopt bylaws, rules, and policies;
- (4) Maintain an office in the District at a place designated by the executive board;
- (5) Enter into any agreements or contracts and execute the instruments necessary to manage its affairs and to carry out the purposes of this chapter;

(6) Apply for and receive grants, contracts, or other public or private funding; and

(7) Do all things necessary in conformity with the law to exercise the powers granted by this chapter.

(d)(1) To carry out the purposes of this chapter or perform any of its functions under this chapter, the executive board may contract or enter into memoranda of understanding with eligible entities, including the:

(A) Department of Health Care Finance;

(B) Department of Human Services;

(C) Department of Insurance, Securities and Banking;

(D) Insurance producers and third-party administrators registered in the District; and

(E) Any other entities that have experience in individual and small group public and private health insurance plans or in facilitating enrollment in those plans.

(2) The executive board shall ensure that any entity under a contract with the Authority complies with the provisions of this chapter when performing services on behalf of the Authority that are subject to this chapter.

(e)(1) The executive board may enter into information-sharing agreements with federal agencies, District agencies, agencies of one or more states, and other state health insurance exchanges to carry out the provisions of this chapter.

(2) An information-sharing agreement entered into under paragraph (1) of this subsection shall:

(A) Include adequate protections with respect to the confidentiality of information; and

(B) Comply with all District and federal laws and regulations.

(f) The executive board shall adopt written policies and procedures governing all procurements of the Authority.

(g) The executive board may limit the number of plans offered in the exchanges using selective criteria or contracting; provided, that individuals and employers have an adequate number and selection of choices.

(h) The executive board may merge the exchanges for individual coverage within the American Health Benefits Exchange and the SHOP Exchange if a merger is considered by the Authority to be in the best interest of the District.

(Mar. 2, 2012, D.C. Law 19-94, § 7, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.07. Advisory board.

(a) In addition to the executive board, there shall be a standing advisory board consisting of 9 members, who shall be residents of the District.

(b) The executive board may create additional advisory boards as it considers appropriate.

(c) The executive board shall solicit the recommendations of, and consult with, the advisory boards on:

- (1) Insurance standards;
- (2) Covered benefits;
- (3) Premiums;
- (4) Plan certification;
- (5) Internet technology system development; and
- (6) Any other policy or operational issues, within the executive board's discretion.

(d) The executive board shall:

- (1) Select the members of the advisory boards;
- (2) Establish the terms of the members;
- (3) Ensure that at least one member of the standing advisory board demonstrates expertise as a health insurance broker or agent;
- (4) Appoint the chair of the standing advisory board;
- (5) Determine the residency requirement of any additional advisory board created; and

(6) Appoint the chair of any additional advisory boards created.

(e)(1) An advisory board member may continue to serve until the appointment of his or her successor.

(2) Vacancies shall be filled by appointment by the executive board for the unexpired term of the appointee's predecessor.

(f) Each person appointed to an advisory board shall have demonstrated and acknowledged expertise on issues related to at least one of the following groups:

- (1) Health professionals;
- (2) Health insurance consumers;
- (3) Disease and demographic-specific advocacy groups;
- (4) Commercial sector health plans;
- (5) Public sector health plans;
- (6) Health insurance brokers;
- (7) Health care consumer interest advocacy;
- (8) Health care foundations;
- (9) Exchange consumers; or
- (10) Such other interests considered necessary.

(Mar. 2, 2012, D.C. Law 19-94, § 8, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.08. Executive director and Authority staff.

(a) The executive board shall hire an executive director within 60 days of a majority of executive board members being confirmed to organize, administer, and manage the operations of the Authority.

(1) The executive director shall not be an employee in the career service and shall serve at the pleasure of the executive board.

(2) The executive director shall become a resident of the District within 180 days of the date of hire.

(b) The executive board shall determine the appropriate compensation for the executive director; provided, that the executive director's compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

(c) Under the direction of the executive board, the executive director shall;

(1) Be the chief administrative officer of the Authority;

(2) Direct, administer, and manage the operations of the Authority; and

(3) Perform all duties necessary to comply with and carry out the provisions of this chapter, other District laws and regulations, and the Federal Act.

(d)(1) The executive director may employ and retain staff for the Authority.

(2) The executive director may retain as independent contractors or employees, and set compensation for:

(A) Attorneys;

(B) Financial consultants; and

(C) Other professionals or consultants necessary to carry out the planning, development, and operations of the Authority and the provisions of this chapter.

(3) Employee compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

(e) Except as otherwise provided in this chapter, an employee or independent contractor of the Authority shall not be subject to any law, regulation or Mayor's Order governing District government compensation, including furloughs, pay cuts, or any other general fund cost-saving measure.

(Mar. 2, 2012, D.C. Law 19-94, § 9, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.09. Health benefit plan certification.

(a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum:

(1) Provide the essential health benefits package described in section 1302(a) of the Federal Act; except, that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (e) of this section, if:

(A) The Authority has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Authority, that the plan does not provide the full range of essential pediatric dental benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchanges;

(2) Obtain prior approval of premium rates and contract language from the Commissioner;

(3) Provide at least a bronze level of coverage, as determined by § 31-3171.04(a)(11), unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Federal Act, and will only be offered to individuals eligible for catastrophic coverage;

(4) Ensure that the cost-sharing requirements of the plan do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) Be offered by a health carrier that:

(A) Is licensed and in good standing to offer health insurance coverage in the District;

(B)(i) Offers at least one qualified health plan at the silver level and at least one plan at the gold level through each component of the Authority in which the health carrier participates;

(ii) For the purposes of this subparagraph, the term "component" refers to the SHOP Exchange and the exchange for individual coverage within the American Health Benefit Exchange;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchanges and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties in violation of § 31-3171.04(c); and

(E) Complies with the regulations established by the Secretary under section 1311(d) of the Federal Act and any other requirements as the Authority may establish;

(6) Meet the requirements of certification pursuant to the authority provided in this chapter and by the Secretary under section 1311(c) of the Federal Act, and rules promulgated pursuant to this chapter or the Federal Act, which include:

(A) Minimum standards in the areas of marketing practices;

(B) Network adequacy;

(C) Essential community providers in underserved areas;

(D) Accreditation;

(E) Quality improvement;

(F) Uniform enrollment forms and descriptions of coverage; and

(G) Information on quality measures for health benefit plan performance; and

(7) Be determined by the Authority that making the plan available through the exchanges is in the interest of qualified individuals and qualified employers.

(b) The Authority shall not withhold certification from a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Authority; or

(3) On the basis that the health benefit plan provides treatments neces-

sary to prevent patients' deaths in circumstances the Authority determines are inappropriate or too costly.

(c) The Authority shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase, and prominently post the information on its publically accessible website;

(2)(A) Make available to the public, in the format described in subparagraph (B) of this paragraph, and submit to the Authority, the Secretary, and the Commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary.

(B) The information required in subparagraph (A) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act;

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider and make this information available to the individual through a website that is publically accessible, and through other means for individuals without access to the Internet; and

(4) Promptly notify affected individuals of price and benefit changes, or other changes in circumstances that could materially impact enrollment or coverage.

(d) The Authority shall not exempt any health carrier seeking certification as a qualified health plan, regardless of the type or size of the health carrier, from District licensure or solvency requirements, and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchanges.

(e)(1) The provisions of this chapter that are applicable to qualified health plans shall also apply, to the extent relevant, to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Authority.

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans

without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Authority or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchanges in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health carrier through a qualified health plan; provided, that the plans are priced separately and are also made available for purchase separately at the same price.

(f) The Authority shall take the information required by subsection (c)(1) of this section, along with the information and the recommendations provided to the Authority by the Commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the health carrier to make plans available through the exchanges.

(Mar. 2, 2012, D.C. Law 19-94, § 10, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.10. Conflicts of interest.

(a)(1) A member of the executive board or of the staff of the Authority shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health carrier or other insurer, an agent or broker, a health professional, or a health care facility or health clinic while serving on the board or on the staff of the Authority.

(2) A member of the executive board or of the staff of the Authority shall not be a member, a board member, or an employee of a trade association of health carriers, health facilities, health clinics, or health professionals while serving on the board or on the staff of the Authority.

(3) A member of the executive board or of the staff of the Authority shall not be a health professional unless he or she receives no compensation for rendering services as a health professional and does not have an ownership interest in a professional health care practice.

(b) No member of the executive board or of the staff of the Authority shall, for one year after the end of the member's service on the board or employment by the Authority, accept employment with any health carrier that offers a qualified health benefit plan through the exchanges.

(c) No member of the executive board shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms

available to the public without regard to official status, aggregating \$250 or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, or employee, or holds any position of management.

(Mar. 2, 2012, D.C. Law 19-94, § 11, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.11. Open meetings.

The executive and advisory boards shall be subject to subchapter IV of Chapter 5 of Title 2 [§ 2-571 et seq.]; except, that the executive board may hold closed sessions when considering matters related to litigation, personnel, contracting, or rates.

(Mar. 2, 2012, D.C. Law 19-94, § 12, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.12. Limitation of liability.

There shall not be any liability, in a private capacity, on the part of the executive or advisory board members, or any officer, or employee of the executive or advisory board, for or on account of any act performed or obligation entered into in an official capacity when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this chapter or affairs related to this chapter.

(Mar. 2, 2012, D.C. Law 19-94, § 13, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.13. Relation to other laws.

(a) Nothing in this chapter, and no action taken by the Authority pursuant to this chapter, shall be construed to preempt or supersede the authority of the Commissioner to regulate the business of insurance within the District. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans and qualified dental plans in the District shall comply fully with all applicable health insurance laws of the District and regulations adopted and orders issued by the Commissioner.

(b) Nothing in this chapter, and no action taken by the Authority pursuant to this chapter, shall be construed to preempt or supersede the authority of the Department of Health Care Finance, as the single state agency, to establish

policy and enforce the rules and regulations governing Titles XIX and XXI of the Social Security Act and other health-care programs under its jurisdiction.

(Mar. 2, 2012, D.C. Law 19-94, § 14, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.14. Powers of the Mayor.

Notwithstanding any other provision of this chapter, all powers and authority vested by this chapter in the Authority shall remain with the Mayor until:

- (1) A majority of members of the executive board have been confirmed by the Council; and
- (2) The executive board has hired an executive director.

(Mar. 2, 2012, D.C. Law 19-94, § 15, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.15. Dissolution of the Authority.

Upon dissolution, liquidation, or other termination of the Authority:

- (1) All rights and properties of the Authority shall pass to and be vested in the District, subject to the rights of lien holders and other creditors;
- (2) Any net earnings of the Authority, beyond that necessary for retirement of any indebtedness or to implement a public purpose or program of the District authorized under this chapter, shall not inure to the benefit of any person other than the District;
- (3) The expenditure of any net earnings shall be restricted to costs related to the direct delivery of health care to residents of the District.

(Mar. 2, 2012, D.C. Law 19-94, § 16, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.16. Implementation and reports.

(a) The executive board shall:

(1) Study, in consultation with the advisory boards established under this chapter and with other stakeholders:

(A) The feasibility and desirability of the Authority engaging in:

(i) Selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality-of-care by certifying only those health benefit plans that meet certain requirements, such as:

- (I) Promoting patient-centered medical homes;
- (II) Adopting electronic health records;

- (III) Meeting minimum outcome standards;
- (IV) Implementing payment reforms to reduce medical errors and preventable hospitalizations;
- (V) Reducing disparities;
- (VI) Ensuring adequate reimbursements;
- (VII) Enrolling high-risk members and underserved populations;
- (VIII) Managing chronic conditions and promoting healthy consumer lifestyles;
- (IX) Value-based insurance design;
- (X) Adhering to transparency guidelines; and
- (XI) Uniform price and quality reporting;
- (ii) Multistate contracting; and
- (iii) Entering into a regional exchange;
- (B) The rules under which health benefit plans should be offered inside and outside the exchanges in order to mitigate adverse selection and encourage enrollment in the exchanges, including:
 - (i) Whether any benefits should be required of qualified health plans beyond those mandated by the Federal Act, and whether any such additional benefits should be required of health benefit plans offered outside the exchanges;
 - (ii) Whether health carriers offering health benefit plans outside the exchanges should be required to offer either all the same health benefit plans inside the exchanges or, alternatively, at least one health benefit plan inside the exchanges;
 - (iii) Whether managed care organizations with Health Choice contracts should be required to offer products inside the exchanges;
 - (iv) Whether health carriers offering health benefit plans inside the exchanges should be required to also participate in the District medical assistance program; and
 - (v) Which provisions applicable to qualified health plans should be made applicable to qualified dental plans;
- (C) The design and operation of the Authority's Navigator program and any other appropriate consumer-assistance mechanisms, including:
 - (i) How the Navigator program could utilize, interact with, or complement private-sector resources, including insurance producers;
 - (ii) The infrastructure of the existing private sector health insurance distribution system in the District to determine whether private sector resources may be available and suitable for use by the Authority;
 - (iii) The effect the exchanges may have on private sector employment in the health insurance distribution system in the District;
 - (iv) What functions, in addition to those required by the Federal Act, should be performed by Navigators;
 - (v) What training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications;
 - (vi) How Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the exchanges can be minimized or avoided;

(vii) How to ensure that Navigators provide information in a manner culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by the Authority, and that Navigators have the capacity to meet these needs; and

(viii) What other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented;

(D) The design and function of the SHOP Exchange beyond the requirements of the Federal Act, to promote quality, affordability, and portability, including:

(i) Whether it should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees;

(ii) Whether the current individual and small group markets should be merged; and

(iii) Whether the SHOP Exchange should be made available to employers with 50 to 100 employees prior to 2016, as authorized by the Federal Act;

(E) How the Authority will ensure financial integrity in compliance with the Federal Act, including:

(i) A recommended plan for the budget of the Authority;

(ii) The user fees, licensing fees, or other assessments that should be imposed by the Authority to fund its operations, including what type of user fee cap or other methodology would be appropriate to ensure that the income of the Authority comports with the expenditures of the Authority; and

(iii) A recommended plan for how to prevent fraud, waste, and abuse; and

(F) How the Authority should conduct its public relations and advertising campaign, including what type of solicitation, if any, of individual consumers or employers, would be desirable and appropriate; and

(2) Report its findings under paragraph (1) of this subsection to the Mayor, Council, and public within 180 days of March 2, 2012.

(b)(1) The executive board shall prepare a plan that identifies how the Authority will be financially self-sustaining by January 1, 2015.

(2) The plan, which shall be certified by an independent actuary as actuarially sound, shall be submitted to the Mayor and Council not later than December 15, 2013.

(Mar. 2, 2012, D.C. Law 19-94, § 17, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.17. Rules.

(a) The Authority, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of this chapter.

(b) The Authority shall submit all proposed rules adopted by the Authority to the Council for a 30-day period of review, excluding Saturdays, Sundays,

legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution, within this 30-day review period, the proposed rules shall be deemed approved.

(c) Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

(Mar. 2, 2012, D.C. Law 19-94, § 18, 59 DCR 213.)

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

§ 31-3171.18. Applicability.

This chapter shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.

(Mar. 2, 2012, D.C. Law 19-94, § 19, 59 DCR 213.)

Emergency legislation. — For temporary (90 day) amendment of section, see § 7015 of Fiscal Year 2013 Budget Support Emergency Act of 2012 (D.C. Act 19-383, June 19, 2012, 59 DCR 7764).

For temporary (90 day) amendment of section, see § 7015 of Fiscal Year 2013 Budget

Support Congressional Review Emergency Act of 2012 (D.C. Act 19-413, July 25, 2012, 59 DCR 9290).

Legislative history of Law 19-94. — For history of Law 19-94, see notes under § 31-3171.01.

CHAPTER 32. HEALTH INSURANCE FORMS.

Subchapter I. Uniform Claims Forms

Sec.

31-3234. Applicability.

Sec.

31-3201. Standardized uniform health insurance claim forms.

*Subchapter III. Uniform Credentialing Forms**Subchapter II. Uniform Consultation Referral Forms*

31-3251. Definitions.

31-3252. Application for becoming credentialed.

31-3231. Definitions.

31-3253. Penalties.

31-3232. Uniform consultation referral forms.

31-3254. Regulations.

31-3233. Regulations.

31-3255. Applicability.

*Subchapter I. Uniform Claims Forms.***§ 31-3201. Standardized uniform health insurance claim forms.**

(a) The HCFA 1500 and UB 92 claims forms, or their successor forms as they may be amended from time to time, shall serve as the official health insurance claims forms of the District of Columbia for hospitals and other medical providers and governmental agencies, and such forms shall be used and exclusively accepted by all insurers, including health maintenance organizations and other forms of managed care, transacting health insurance, providing medical insurance through a personal automobile policy, workers' compensation, or otherwise providing coverage for medical services, and by all hospitals, medical providers, and government agencies in the District of Columbia that require insurance claim forms for their records.

(b) The claims forms specified in subsection (a) of this section may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

(Feb. 27, 1996, D.C. Law 11-89, § 2, 42 DCR 7153.)

Prior Codifications. — 1981 Ed., § 35-2331.

Legislative history of Law 11-89. — Law 11-89, the "Uniform Health Insurance Claim Forms Act of 1995," was introduced in Council and assigned Bill No. 11-44, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-172 and transmitted to both Houses of Congress for its review. D.C. Law 11-89 became effective on February 27, 1996.

*Subchapter II. Uniform Consultation Referral Forms.***§ 31-3231. Definitions.**

For the purposes of this subchapter, the term:

(1) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or

disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(3) "Commissioner" means the Commissioner of the Department of Insurance and Securities Regulation.

(April 13, 2002, D.C. Law 14-97, § 2, 49 DCR 994.)

Legislative history of Law 14-97. — Law 14-97, the "Uniform Consultation Referral Forms Act of 2002", was introduced in Council and assigned Bill No. 14-55, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 4, 2001, and January 8, 2002, respectively. Signed by the Mayor on January 28, 2002, it was assigned Act No. 14-230 and transmitted to both Houses of Congress for its review. D.C. Law 14-97 became effective on April 13, 2002.

§ 31-3232. Uniform consultation referral forms.

(a) This subchapter shall apply to all health insurers that issue or deliver individual or group health benefit plans in the District of Columbia.

(b) All health insurers that require the insured to have a written referral to receive consultation services shall use the uniform consultation referral form adopted by the Commissioner as the sole instrument for referrals for consultation services.

(c) The uniform consultation referral form shall be properly completed by the health care provider that refers the insured for consultation services.

(April 13, 2002, D.C. Law 14-97, § 3, 49 DCR 994.)

Legislative history of Law 14-97. — For Law 14-97, see notes following § 31-3231.

§ 31-3233. Regulations.

(a) The Commissioner shall promulgate regulations to implement the provisions of this subchapter. The regulations shall include a uniform consultation referral form for use by health insurers that require enrollees or subscribers to have a written referral to receive consultation services.

(b) The Commissioner may waive the requirements of regulations adopted

under subsection (a) of this section for the use of uniform consultation referral forms for an entity that uses the forms solely for internal purposes.

(April 13, 2002, D.C. Law 14-97, § 4, 49 DCR 994.)

Legislative history of Law 14-97. — For Law 14-97, see notes following § 31-3231.

§ 31-3234. Applicability.

This subchapter shall apply to health insurers beginning with referrals issued 120 days after the promulgation of final regulations under § 31-3233.

(April 13, 2002, D.C. Law 14-97, § 5, 49 DCR 994.)

Legislative history of Law 14-97. — For Law 14-97, see notes following § 31-3231.

Subchapter III. Uniform Credentialing Forms.

§ 31-3251. Definitions.

For the purposes of this subchapter, the term:

(1) “Commissioner” means Commissioner of the Department of Insurance and Securities Regulation.

(2) “Credentialing intermediary” means a person to whom a health insurer has delegated credentialing or recredentialing authority and responsibility.

(3) “Health benefit plan” means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term “health benefit plan” does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) “Health care provider” means:

(A) An individual who is licensed, certified, or otherwise authorized to provide health care services by the District of Columbia for a practice set forth under § 3-1201.02; or

(B) An agency, organization, facility, or distinct part of any of them, licensed under subchapter I of Chapter 5 of Title 44.

(5) “Health insurer” means any person that provides one or more health

benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Provider panel" means providers that contract with a health insurer to provide health care services to the enrollees under a health benefit plan of the health insurer.

(7) "Uniform credentialing form" means the form designed by the Commissioner, by regulation, for use by a health insurer or its credentialing intermediary for credentialing and re-credentialing of a health care provider for participation on a provider panel.

(Apr. 13, 2002, D.C. Law 14-96, § 101, 49 DCR 991.)

Legislative history of Law 14-96. — Law 14-96, the "Health Insurers and Credentialing Intermediaries Uniform Credentialing Form Act of 2002", was introduced in Council and assigned Bill No. 14-54, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and

second readings on December 4, 2001, and January 8, 2002, respectively. Signed by the Mayor on January 28, 2002, it was assigned Act No. 14-229 and transmitted to both Houses of Congress for its review. D.C. Law 14-96 became effective on April 13, 2002.

§ 31-3252. Application for becoming credentialed.

(a) A health insurer or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the health insurer.

(b) A health insurer or its credentialing intermediary shall make the uniform credentialing form available to any health care provider that is to be credentialed or re-credentialled by the health insurer or credentialing intermediary.

(Apr. 13, 2002, D.C. Law 14-96, § 102, 49 DCR 991.)

Legislative history of Law 14-96. — For D.C. Law 14-96, see notes following § 31-3251.

§ 31-3253. Penalties.

The Commissioner may impose a penalty not to exceed \$500 against any health insurer for each violation of this subchapter by the health insurer or its credentialing intermediary.

(Apr. 13, 2002, D.C. Law 14-96, § 103, 49 DCR 991.)

Legislative history of Law 14-96. — For D.C. Law 14-96, see notes following § 31-3251.

§ 31-3254. Regulations.

The Commissioner shall promulgate rules and regulations to implement the provisions of this subchapter.

(Apr. 13, 2002, D.C. Law 14-96, § 104, 49 DCR 991.)

Legislative history of Law 14-96. — For D.C. Law 14-96, see notes following § 31-3251.

§ 31-3255. Applicability.

This subchapter shall apply, 120 days after the promulgation of the final regulations pursuant to § 31-3254, to health insurers, as defined in § 31-3251(5), and any agency, organization, facility, or distinct part thereof, licensed pursuant to subchapter I of Chapter 5 of Title 44.

(Apr. 13, 2002, D.C. Law 14-96, § 105, 49 DCR 991.)

Legislative history of Law 14-96. — For D.C. Law 14-96, see notes following § 31-3251.

CHAPTER 32A. HEALTH INSURANCE COVERAGE FOR HABILITATIVE SERVICES FOR CHILDREN.

Sec.

31-3271. Definitions.

31-3272. Coverage, notice, applicability, and regulations.

§ 31-3271. Definitions.

For the purposes of this chapter, the term:

(1)(A) "Adverse decision" means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

(i) A proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient;

(ii) May result in noncoverage of the health care service; and

(iii) Does not include a decision concerning a subscriber's status as a member.

(B) A determination denying a request for habilitative services or denying payment for habilitative services because a condition or disease is not a congenital or genetic birth defect is an adverse decision.

(2) "Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. The term "congenital or genetic birth defect" includes:

(A) Autism or an autism spectrum disorder; and

(B) Cerebral palsy.

(3) "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

(4)(A) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement.

(B) The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a

hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Managed care system" means a method that a health insurer uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(Mar. 2, 2007, D.C. Law 16-198, § 2, 53 DCR 8829.)

Legislative history of Law 16-198. — Law 16-198, the "Health Insurance Coverage for Habilitative Services for Children Act of 2006", was introduced in Council and assigned Bill No. 16-711, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings

on July 11, 2006, and October 3, 2006, respectively. Signed by the Mayor on October 23, 2006, it was assigned Act No. 16-493 and transmitted to both Houses of Congress for its review. D.C. Law 16-198 became effective on March 2, 2007.

§ 31-3272. Coverage, notice, applicability, and regulations.

(a) A health insurer shall:

(1) Provide coverage of habilitative services for children under the age of 21 years and may do so through a managed care system;

(2) Not be required to provide reimbursement for habilitative services actually delivered through early intervention or school services; and

(3) Provide notice to its insureds and enrollees about the coverage required under this chapter.

(b) The coverage shall not be more restrictive than coverage provided for any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

(c) The Commissioner may issue rules and regulations necessary to implement the provisions of this chapter.

(d) This chapter shall apply to all individual and group health benefit plans issued or renewed on the first day of the month beginning on or after 90 days following March 2, 2007.

(Mar. 2, 2007, D.C. Law 16-198, § 3, 53 DCR 8829.)

Legislative history of Law 16-198. — For Law 16-198, see notes following § 31-3272.

CHAPTER 33. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY.

Subchapter I. General Provisions

Subchapter III. Group Insurance

Sec.

31-3301.01. Definitions.

Subchapter II. Individual Health Insurance

31-3302.01. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

31-3302.02. Special rules for network plans.

31-3302.03. Application of financial capacity limits.

31-3302.04. Market requirements.

31-3302.05. Renewability of individual health insurance coverage.

31-3302.06. Fair market provision.

31-3302.07. Regulations establishing standards.

31-3302.08. Applicability.

31-3302.09. Construction.

Sec.

31-3303.01. Application of subchapter.

31-3303.02. Availability of health benefit plans to small employers.

31-3303.03. Renewability.

31-3303.04. Reference to plan sponsor.

31-3303.05. Coverage.

31-3303.06. Availability.

31-3303.07. Limitation on preexisting condition exclusion period.

31-3303.08. Disclosure of information.

31-3303.09. Eligibility to enroll.

31-3303.10. Exclusions.

31-3303.11. Rules used to determine group size.

31-3303.12. Affiliation period.

31-3303.13. Alternative methods.

31-3303.14. Applicability.

Subchapter I. General Provisions.

§ 31-3301.01. Definitions.

For the purposes of this chapter, the term:

(1) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period. Such period shall begin on the enrollment date. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(2) "Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 834; 29 U.S.C. § 1002(8)).

(3) "Bona fide association" means, with respect to health insurance coverage offered in the District of Columbia, an association which:

(A) Has been actively in existence for at least 5 years;

(B) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) Does not make health insurance coverage offered through the

association available other than in connection with a member of the association; and

(F) Meets such additional requirements as may be imposed under the laws of the District of Columbia.

(4) "Certification" means a written certification of the period of creditable coverage applicable to an individual.

(5) "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 838; 29 U.S.C. § 1002(33)).

(6) "COBRA continuation provision" means any of the following:

(A) Section 3011(a) of the Internal Revenue Code of 1986, approved November 10, 1988 (102 Stat. 3616; 26 U.S.C. § 4980B), other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines;

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, approved April 7, 1986 (100 Stat. 227; 29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

(C) Title XXII of the Public Health Service Act, approved July 1, 1994 (100 Stat. 232; 42 U.S.C. § 300bb-1 et seq.).

(7) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(8)(A) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or B of title XVIII of the Social Security Act, approved July 30, 1965 (79 Stat. 291; 42 U.S.C. § 1395c et seq. or 1395j et seq., respectively);

(iv) Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

(v) Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

(ix) A public health plan (as defined in regulations); or

(x) A health benefit plan under section 5(e) of the Peace Corps Act, approved September 22, 1961 (75 Stat. 614; 22 U.S.C. § 2504(e)).

(B) "Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits.

(9) "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

(9A) "Domestic partnership" shall have the same meaning as provided in § 32-701(4).

(10) "Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has

satisfied applicable waiting period requirements, and is not a part-time, temporary, or substitute employee.

(11) "Eligible individual" means an individual:

(A)(i) For whom, as of the date on which the individual seeks individual coverage under this chapter, the aggregate of the periods of creditable coverage is 18 or more months, and (ii) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

(B) Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a state plan under title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 et seq.), or any successor program, and does not have other health insurance coverage;

(C) With respect to whom the most recent coverage within the coverage period described in subparagraph (A) of this paragraph was not terminated based on a factor described in § 31-3302.05(b) relating to nonpayment of premiums or fraud;

(D) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

(E) Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(12) "Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, approved September 12, 1974 (88 Stat. 834; 29 U.S.C. § 1002(5)), except that such term shall include only employers of 2 or more employees.

(13) "Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(14) "Established geographic service area" means the District of Columbia.

(15) "Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(A) Benefits not subject to the requirements of this chapter including:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Medical expense and loss of income benefits;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; and

(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(B) Benefits not subject to the requirements of this chapter if offered separately including:

- (i) Limited scope dental or vision benefits;
- (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- (iii) Such other similar, limited benefits as are specified in regulations;

(C) Benefits not subject to the requirements of this chapter if offered as independent, noncoordinated benefits including:

- (i) Coverage only for a specified disease or illness; and
- (ii) Hospital indemnity or other fixed indemnity insurance; and

(D) Benefits not subject to the requirements of this chapter if offered as a separate insurance policy including:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act, approved June 9, 1980 (72 Stat. 1445; 42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(16) “Federal governmental plan” means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

(17) “Governmental plan” has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 837; 29 U.S.C. § 1002(32)) and any federal governmental plan.

(18) “Group health insurance coverage” means health insurance coverage offered in connection with a group health plan.

(19) “Group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(20) “Health benefit plan” means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term “health benefit plan” does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers’ compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or

insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(21) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(22) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(23) "Health maintenance organization" means:

(A) A federally qualified health maintenance organization;

(B) An organization recognized under the laws of the District of Columbia as a health maintenance organization; or

(C) A similar organization regulated under the laws of the District of Columbia for solvency in the same manner and to the same extent as such a health maintenance organization.

(24) "Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurer:

(A) Health status;

(B) Medical condition (including both physical and mental illnesses);

(C) Claims experience;

(D) Receipt of health care;

(E) Medical history;

(F) Genetic information;

(G) Evidence of insurability (including conditions arising out of acts of domestic violence); or

(H) Disability.

(25) "High level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is:

(A) At least 15% greater than the actuarial value of the low level policy form coverage offered by the carrier in the District of Columbia; and

(B) At least 100%, but not greater than 120%, of the weighted average.

(26) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. The term "individual health insurance coverage" does not include short-term limited duration coverage.

(27) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(28) "Initial enrollment period" means a period of at least 30 days.

(29) "Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an

employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(30) “Large group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or through a health insurer.

(31) “Late enrollee” means an eligible employee or dependent who requests enrollment in a group health benefit plan after the initial enrollment period provided under the terms of the group health benefit plan, or a participant or beneficiary who enrolls under the plan other than during (i) the first period in which the individual is eligible to enroll under the plan, or (ii) a special enrollment period as required pursuant to this statute. An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subparagraphs (A) through (D) of this paragraph are met, or one of the conditions set forth below in subparagraphs (E) or (F) of this paragraph is met:

(A) The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll;

(B) The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment;

(C) The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan’s entire group coverage, death of a spouse, or divorce;

(D) The individual requests enrollment within 30 days after termination of coverage provided under a public or private health benefit plan;

(E) The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period; or

(F) A court has ordered that coverage be provided for a spouse or minor child under a covered employee’s health benefit plan, the minor is eligible for coverage and is a dependent, and the request for enrollment is made within 30 days after issuance of such court order. However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee’s prior plan.

(32) “Low level policy form” means a policy or plan under which the actuarial value of the benefit under the coverage is at least 85%, but not greater than 100%, of the weighted average.

(33) “Medical care” means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

(34) “Network plan” means health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurer.

(35) "Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

(36) "Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 834; 29 U.S.C. § 1002(7)).

(37) "Placed for adoption", "placement", or "being placed for adoption", in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(38) "Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 835; 29 U.S.C. § 1002(16)(B)).

(39) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(40) "Preexisting conditions provision" means a provision in a health benefit plan that limits, denies, or excludes benefits for an enrollee for expenses or services related to a preexisting condition.

(41) "Premium" means all moneys paid by a small employer and eligible employees as a condition of coverage from a health insurer, including fees and other contributions associated with the health benefit plan.

(42) "Small employer" means an employer who employed an average of at least 2, but not more than 50, employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(43) "State" means each of the several states, and the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(44) "Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(45)(A) "Weighted average" means the average actuarial value of the benefits provided by:

(i) All the health insurance coverages issued (as elected by the health insurer) either by that health insurer or by all health insurers in the District of Columbia in the individual market during the previous calendar year (not including coverage issued under this section), weighted by enrollment for the different coverages; or

(ii) All the health insurance coverages issued by all health insurers in the District of Columbia in the individual market, if the data are available,

during the previous calendar year, weighted by enrollment for the different coverages.

(B) The term “weighted average” does not include coverages issued pursuant to § 31-3302.01(d)(1).

(C) The health insurer shall elect biennially, as provided in § 31-3302.01(d)(3), whether to calculate the weighted average using the methodology in subparagraph (A)(i) or (ii) of this paragraph.

(Apr. 13, 1999, D.C. Law 12-209, § 101, 45 DCR 8433; June 11, 2004, D.C. Law 15-166, § 4(s)(1), 51 DCR 2817; Sept. 12, 2008, D.C. Law 17-231, § 27(a), 55 DCR 6758.)

Prior Codifications. — 1981 Ed., § 35-1021.

Effect of amendments. — D.C. Law 15-166, in par. (7), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of the Department of Insurance and Securities Regulation”.

D.C. Law 17-231 added par. (9A).

Temporary Addition of Section. — Sections 101 through 314 of D.C. Law 12-27 and D.C. Law 12-154 enacted §§ 35-1021 through 35-1044, comprising Chapter 10A of Title 35 (1981 Ed.).

Emergency legislation. — For temporary addition of chapter, see §§ 101-314 of the Health Insurance Portability and Accountability Federal Law Conformity and Accountability Emergency Act of 1997 (D.C. Act 12-96, July 2, 1997, 44 DCR 4000), §§ 101-314 of the Health Insurance Portability and Accountability Federal Law Conformity Congressional Recess Emergency Act of 1997 (D.C. Act 12-151, September 29, 1997, 44 DCR 5769), and §§ 101-314 of the Health Insurance Portability and Accountability Federal Law Conformity Emergency Amendment Act of 1998 (D.C. Act 12-339, May 4, 1998, 45 DCR 2947).

For temporary addition of chapter, see §§ 101-314 of the Health Insurance Portability and Accountability Federal Law Conformity, Motor Vehicle Insurance, Regulatory Reform, and Consumer Law Congressional Review Emergency Amendment Act of 1998 (D.C. Act 12-429, August 6, 1998, 45 DCR 5890).

For temporary (90 day) amendment of section, see § 4(s)(1) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) workers’ compensation and health insurance and portability and accountability approval requirement, see § 1122 of Fiscal Year 2005 Budget Support Emergency Act of 2004 (D.C. Act 15-486, August 2, 2004, 51 DCR 8236).

For temporary (90 day) workers’ compensation and health insurance and portability and

accountability approval requirement, see § 1122 of Fiscal Year 2005 Budget Support Congressional Review Emergency Act of 2004 (D.C. Act 15-594, October 26, 2004, 51 DCR 11725).

Legislative history of Law 12-209. — Law 12-209, the “Health Insurance Portability and Accountability Federal Law Conformity and No-Fault Motor Vehicle Insurance Act of 1998,” was introduced in Council and assigned Bill No. 12-419, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second reading on July 7, 1998, and September 22, 1998, respectively. Signed by the Mayor on October 16, 1998, it was assigned Act No. 12-496, and transmitted to both Houses of Congress for its review. D.C. Law 12-209 became effective on April 13, 1999.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 15-205. — Law 15-205, the “Fiscal Year 2005 Budget Support Act of 2004,” was introduced in Council and assigned Bill No. 15-768, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 14, 2004, and June 29, 2004, respectively. Signed by the Mayor on August 2, 2004, it was assigned Act No. 15-487 and transmitted to both Houses of Congress for its review. D.C. Law 15-205 became effective on December 7, 2004.

Legislative history of Law 17-231. — Law 17-231, the “Omnibus Domestic Partnership Equality Amendment Act of 2008,” was introduced in Council and assigned Bill No. 17-135, which was referred to the Committee on Public Safety and the Judiciary. The Bill was adopted on first and second readings on April 1, 2008, and May 6, 2008, respectively. Signed by the Mayor on June 6, 2008, it was assigned Act No. 17-403 and transmitted to both Houses of Congress for its review. D.C. Law 17-231 became effective on September 12, 2008.

Short title. — Short title of subtitle L of title I of Law 15-205: Section 1121 of D.C. Law

15-205 provided that subtitle L of title I of the act may be cited as the Workers' Compensation and Health Insurance Portability and Accountability Approval Requirement Act of 2004.

Editor's notes. — Section 1122 of D.C. Law 15-205 provided: "No funds shall be expended

relating to the Health Insurance Portability and Accountability Act, approved August 21, 1996 (104 Pub. L. No. 191; 110 Stat. 1936), and the District's Workers' Compensation administration without affirmative approval of the expenditure by the Council."

Subchapter II. Individual Health Insurance.

§ 31-3302.01. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

(a) This subchapter applies only to those health insurers that offer individual health insurance coverage in the District of Columbia. Nothing in this subchapter shall require health insurers participating only in the group health insurance market to offer individual health insurance coverage.

(b) A health insurer may not offer any individual health benefit plans in the District of Columbia unless the health insurer offers, and actively markets, the policies required by this section.

(c) Unless a health insurer makes an election under subsection (d)(2) of this section, the health insurer may not:

(1) Decline to offer coverage to, or deny enrollment of, an eligible individual; or

(2) Impose any preexisting condition provision on an eligible individual.

(d)(1) A health insurer that makes an election under paragraph (2) of this subsection may choose to offer at least 2 different policy forms, both of which are designed for, made generally available to, actively marketed to, and enroll both eligible individuals and other individuals. Policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) No later than July 1, 1997, a health insurer that intends to offer 2 policy forms shall submit in writing to the Commissioner both:

(A) An election whether to offer (i) a high level and low level policy form, each of which includes benefits substantially similar to other individual health insurance coverage offered by the health insurer in the District of Columbia, or (ii) policy forms with the largest and next to largest premium volume of all policy forms offered by the health insurer in the District of Columbia; and

(B) An election as to which methodology the health insurer will use to determine the weighted average valuation as defined in § 31-3301.01(45).

(3) An election made under this section shall be binding for a 2-year period. After the initial 2-year period, and for each subsequent 2-year period, a health insurer shall again make the elections required by this section.

(4) An election shall be made on a form and in a manner required by the Commissioner.

(5) The actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(6) A health insurer shall submit any information the Commissioner may require to support and justify the health insurer's calculations of actuarial values.

(7) A health insurer shall issue the individual health benefit plan elected under this section to any eligible individual.

(8) A health insurer shall not impose any pre-existing condition provision on an eligible individual.

(Apr. 13, 1999, D.C. Law 12-209, § 201, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1022.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.02. Special rules for network plans.

(a) A health insurer that offers health insurance coverage in the individual market may:

(1) Limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

(2) Within the service area of such plan, deny such coverage to such individuals if the health insurer has demonstrated to the Commissioner that:

(A) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders, enrollees, and enrollees covered under individual contracts; and

(B) It is applying this section uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(b) A health insurer, upon denying health insurance coverage in the District of Columbia in accordance with subsection (a)(2) of this section, may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(Apr. 13, 1999, D.C. Law 12-209, § 202, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1023.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.03. Application of financial capacity limits.

(a) A health insurer may deny health insurance coverage in the individual

market to an eligible individual if the health insurer has demonstrated to the satisfaction of the Commissioner that:

(1) It does not have the financial reserves necessary to underwrite additional coverage; and

(2) It is applying this section uniformly to all individuals in the individual market in the District of Columbia consistent with the laws of the District of Columbia and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(b) A health insurer, upon denying individual health insurance coverage in the District of Columbia in accordance with subsection (a) of this section, may not offer such coverage in the individual market within the District of Columbia for a period of 180 days after the date such coverage is denied or until the health insurer has demonstrated to the satisfaction of the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(Apr. 13, 1999, D.C. Law 12-209, § 203, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1024.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.04. Market requirements.

(a) The provisions of this chapter shall not be construed to require that a health insurer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

(b) A health insurer offering health insurance coverage in connection with group health plans under this subchapter shall not be deemed to be a health insurer offering individual health insurance coverage solely because such issuer offers a conversion policy.

(c) A health insurer offering individual health insurance coverage solely because such insurer offers any insurance coverage for children as a participant in a pilot program relating to insurance coverage for children shall not be deemed to be a health insurer offering individual health insurance coverage.

(Apr. 13, 1999, D.C. Law 12-209, § 204, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1025.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.05. Renewability of individual health insurance coverage.

(a) Except as provided in this section, a health insurer that provides individual health insurance coverage shall renew or continue in force such coverage at the option of the individual.

(b) A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The insurer is ceasing to offer coverage in the individual market in accordance with this chapter;

(4) In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the health insurer is authorized to do business, but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals; or

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this section uniformly without regard to any health status-related factor of covered individuals.

(c) *Requirements for uniform termination of coverage. —*

(1) *Discontinuance of a particular type of health insurance coverage.*

In any case in which a health insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the health insurer only if:

(i) The health insurer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(ii) The health insurer offers to each individual in the individual market provided coverage of this type the option to purchase any other individual health insurance coverage currently being marketed by the health insurer for individuals in such market; and

(iii) In exercising the option to discontinue coverage of this type, and in offering the option of coverage under this subsection, the health insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) *Discontinuance of all coverage.*

(A) Subject to paragraph (1)(iii) of this subsection, in any case in which a health insurer elects to discontinue offering all health insurance coverage in

the individual market in the District of Columbia, health insurance coverage may be discontinued by the health insurer only if:

(i) The health insurer provides notice to the Commissioner and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) All health insurance issued or delivered for issuance in the District of Columbia in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

(B) In the case of discontinuation under paragraph (1) of this subsection in the individual market, the health insurer may not provide for the issuance of any health insurance coverage in the individual market in the District of Columbia during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) At the time of coverage renewal, a health insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of the District of Columbia and effective on a uniform basis among all individuals with that policy form.

(e) In applying this section in the case of health insurance coverage that is made available by health insurers in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

(Apr. 13, 1999, D.C. Law 12-209, § 205, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1026.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.06. Fair market provision.

The provisions of § 31-3303.07(j) shall apply to health insurance coverage offered by a health insurer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurer in connection with a group health plan in the small or large group market.

(Apr. 13, 1999, D.C. Law 12-209, § 206, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1027.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.07. Regulations establishing standards.

(a) The Commissioner may adopt regulations to enable him or her to

establish and administer such standards relating to the provisions of this chapter as may be necessary to (i) implement the requirements of this chapter, and (ii) assure that the District of Columbia's regulation of health insurers is not preempted pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (P.L. 104-191; 110 Stat. 1936).

(b) The Commissioner may revise or amend such regulations and may increase the scope of the regulations to the extent necessary to maintain federal approval of the District of Columbia's program for regulation of health insurers pursuant to the requirements established by the United States Department of Health and Human Services.

(c) The Commissioner shall annually advise the Committee on Consumer and Regulatory Affairs, or such other Council committee or committees having subject matter jurisdiction over health insurance, of revisions and amendments made pursuant to subsection (b) of this section.

(Apr. 13, 1999, D.C. Law 12-209, § 207, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1028.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.08. Applicability.

Unless otherwise specifically provided in this chapter, the provisions of this subchapter shall apply to individual health benefit plans issued or renewed on or after January 1, 1998.

(Apr. 13, 1999, D.C. Law 12-209, § 208, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1029.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3302.09. Construction.

Nothing in this subchapter shall be construed to:

(1) Restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market; or

(2) Prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(Apr. 13, 1999, D.C. Law 12-209, § 209, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1030.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

Subchapter III. Group Insurance.

§ 31-3303.01. Application of subchapter.

This subchapter applies to health insurers offering group health insurance coverage. Each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers coverage to the group market in the District of Columbia shall be subject to the provisions of this subchapter if any of the following conditions are met:

(1) Any portion of the premiums or benefits is paid by or on behalf of the employer;

(2) The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer, for any portion of the premium; or

(3) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of section 106, 125, or 162 of the United States Internal Revenue Code [26 U.S.C. § 106, 26 U.S.C. § 125, or 26 U.S.C. § 162].

(Apr. 13, 1998, D.C. Law 12-209, § 301, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1031.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For

legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

References in text. — Sections 106, 125, and 162 of the United States Internal Revenue Code, referred to in (3), are 26 U.S.C. §§ 106, 125, and 162.

§ 31-3303.02. Availability of health benefit plans to small employers.

In order to ensure the broadest availability of health benefit plans to small employers, the Commissioner shall set market conduct and other requirements for health insurers, agents, and third-party administrators, including requirements relating to the following:

(1) Registration with the Commissioner by each group health insurer offering group health insurance coverage of its intention to offer health insurance coverage in the small group market under this subchapter;

(2) Publication by the Commissioner of a list of all health insurers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurers that no health benefit plan may be sold to a small employer by a health insurer not identified as a health insurer in the small group market;

(3) The availability of a broadly publicized telephone number for the Department of Insurance, Securities, and Banking for access by small employers to information concerning this subchapter; and

(4) Methods concerning periodic demonstration by health insurers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers.

(Apr. 13, 1999, D.C. Law 12-209, § 302, 45 DCR 8433; June 11, 2004, D.C. Law 15-166, § 4(s)(2), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-1032.

Effect of amendments. — D.C. Law 15-166, in par. (3), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

For temporary (90 day) amendment of section, see § 4(s)(2) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-3303.03. Renewability.

(a) Every health insurer that offers health insurance coverage in the group market in the District of Columbia shall renew such coverage with respect to all insureds at the option of the employer except:

(1) For nonpayment of the required premiums by the policyholder or contract holder, or where the health insurer has not received timely premium payments;

(2) When the health insurer is ceasing to offer coverage in the small or large group market in accordance with paragraphs (9) and (10) of this subsection;

(3) For fraud or misrepresentation by the employer with respect to their coverage;

(4) With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

(5) For failure to comply with contribution and participation requirements defined by the health benefit plan;

(6) For failure to comply with health benefit plan provisions that have been approved by the Commissioner;

(7) When a health insurer offers health insurance coverage in the group market through a network plan and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurer (or in the area for which the health insurer is authorized to do business), and, in the case of the group market, the health insurer would deny

enrollment with respect to such plan under the provisions of paragraphs (9) and (10) of this subsection;

(8) When health insurance coverage is made available in the group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this section uniformly without regard to any health status related factor relating to any covered individual;

(9) When a health insurer decides to discontinue offering a particular type of group health insurance coverage in the small or large group market in the District of Columbia, coverage of such type may be discontinued by the health insurer in accordance with the laws of the District of Columbia in such market only if the health insurer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuance; or

(10)(A) In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small or large group market in the District of Columbia, health insurance coverage may be discontinued by the health insurer only in accordance with the laws of the District of Columbia and if:

(i) The health insurer provides notice to the Commissioner and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) All health insurance issued or delivered for issuance in the District of Columbia in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) In the case of a discontinuation in the market, the health insurer may not provide for the issuance of any health insurance coverage in the market involved during the 5-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

(b) At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health plan in the large group market, or, in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with the law of the District of Columbia and effective on a uniform basis among health insurers with that product.

(Apr. 13, 1999, D.C. Law 12-209, § 303, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1033.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.04. Reference to plan sponsor.

In applying this subchapter in the case of health insurance coverage that is made available by a health insurer in the group market to employers only through one or more associations, a reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(Apr. 13, 1999, D.C. Law 12-209, § 304, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1034.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see His-

torical and Statutory Notes following § 31-3301.01.

Editor’s notes. — Temporary addition of chapter: See Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.05. Coverage.

If coverage to the small or large employer market pursuant to this subchapter ceases to be written, administered, or otherwise provided, such coverage shall continue to be governed by this subchapter with respect to business conducted under this subchapter that was transacted prior to the effective date of termination and that remains in force.

(Apr. 13, 1999, D.C. Law 12-209, § 305, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1035.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.06. Availability.

(a) If coverage is offered to small employers under this subchapter, such coverage shall be offered and made available to every small employer that applies for such coverage. Participation in such plan shall be made available to all the eligible employees of a covered small employer and their dependents. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status.

(b) No coverage offered under this subchapter shall exclude an employer based solely on the nature of the employer’s business.

(c) Subsection (a) of this section shall not apply to health insurance coverage offered by a health insurer if such coverage is made available in the small group market only through one or more bona fide associations.

(d) A health insurer that offers health insurance coverage in a small group market through a network plan may:

(1) Limit the employees that may apply for such coverage to those eligible

individuals who live, work, or reside in the service area for such network plan; or

(2) Within the service area of such plan, deny such coverage to such employers if the health insurer has demonstrated, if required, to the satisfaction of the Commissioner that:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(B) It is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

(e) A health insurer, upon denying health insurance coverage in the District of Columbia in accordance with subsection (d)(2) of this section, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

(f) A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated, if required, to the satisfaction of the Commissioner that:

(1) It does not have the financial reserves necessary to underwrite additional coverage; and

(2) It is applying this subdivision uniformly to all employers in the small group market in the District of Columbia consistent with the laws of this District of Columbia and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(g)(1) No health insurer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subsection (a) of this section if the Commissioner determines that acceptance of an application or applications would result in the health insurer being declared an impaired insurer.

(2) A health insurer offering group health insurance coverage that does not offer coverage pursuant to subsection (f) of this section may not offer coverage to small employers until the Commissioner determines that the health insurer is no longer impaired.

(h) A health insurer upon denying health insurance coverage in connection with group health plans in accordance with subsection (d) of this section in the District of Columbia may not offer coverage in connection with group health plans in the small group market for a period of 180 days after the date such coverage is denied or until the health insurer has demonstrated to the satisfaction of the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(i)(1) Nothing in this chapter shall be construed to preclude a health insurer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market.

(2) As used in this subchapter, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer

contribution toward the premium for enrollment of eligible individuals, and the term “group participation rule” means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees.

(3) Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

(j)(1) A group health plan or health insurer offering group health insurance coverage that fails to fairly market to small employers as required by this section may not offer coverage in the District of Columbia to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commissioner or the date on which the health insurer submits, and the Commissioner approves, a plan to fairly market to the health insurer’s established geographic service area.

(2) No health maintenance organization is required to offer coverage or accept applications pursuant to subsection (a) of this section in the case of any of the following:

(A) To small employers where the policy would not be delivered or issued for delivery in the health maintenance organization’s approved service areas;

(B) To an employee where the employee does not reside or work within the health maintenance organization’s approved service areas; or

(C) Within an area where the health maintenance organization demonstrates to the satisfaction of the Commissioner that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(3) A health maintenance organization that does not offer coverage pursuant to this subsection may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the later of 180 days after closure to new applications or the date on which the carrier health maintenance organization notifies the Commissioner that it has regained capacity to deliver services to small employers.

(Apr. 13, 1999, D.C. Law 12-209, § 306, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1036.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.07. Limitation on preexisting condition exclusion period.

(a) Subject to subsection (b) of this section, a health insurer offering group health insurance coverage may, with respect to a participant or beneficiary,

impose a preexisting limitation only if (i) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date, (ii) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date, and (iii) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b)(1) Subject to paragraph (4) of this subsection, a group health plan, and a health insurer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to paragraph (4) of this subsection, a group health plan, and a health insurer offering health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) A group health plan, and health insurer offering health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Paragraphs (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(c) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(d) For purposes of subsections (b)(4) and (c) of this section, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage), or is in an affiliation period, shall not be taken into account in determining the continuous period under subsection (c) of this section.

(e)(1) Except as otherwise provided under paragraph (2) of this subsection, a group health plan and a health insurer offering group health coverage shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(2) A group health plan, or a health insurer offering group health insurance coverage, may elect to count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits rather than as provided under paragraph (1) of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(3) In the case of an election with respect to a group plan under paragraph (2) of this subsection (whether or not health insurance coverage is provided in connection with such plan), the plan shall:

(A) Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election; and

(B) Include in such statements a description of the effect of this election.

(4) In the case of an election under paragraph (2) of this subsection with respect to health insurance coverage offered by a health insurer in the small or large group market, the health insurer shall:

(A) Prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made such election; and

(B) Include in such statements a description of the effect of such election.

(f) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (g) of this section or in such other manner as may be specified in federal regulations.

(g) A health insurer offering group health insurance coverage shall provide for certification of the period of creditable coverage:

(1) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under such provision; and

(3) At the request, or on behalf of, an individual made not later than 24 months after the date of cessation of the coverage described in paragraphs (1) or (2) of this subsection, whichever is later. The certification under paragraph (1) of this subsection may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(h) In the case of an election described in subsection (e)(2) of this section by a group health insurer, if the group health plan or health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subsection (f) of this section:

(1) Upon request of such group health insurer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting insurer information on coverage of classes and categories of health benefits available under such entity's plan or coverage; and

(2) Such entity may charge the requesting group health plan or health insurer for the reasonable cost of disclosing such information.

(i) A health insurer offering group health insurance coverage shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage as a late enrollee for coverage under the terms of the plan if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(3) The employee's or dependent's coverage described in paragraph (1) of this subsection: (i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(4) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in paragraph (3)(i) of this subsection or termination of coverage or employer contribution described in paragraph (3)(ii) of this subsection.

(j) A health insurer is deemed to make coverage available with respect to a dependent of an individual if:

(1) The individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period); and

(2) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the group health insurer shall provide for a dependent special enrollment period during which the person (or, if not otherwise enrolled, the individual) may also be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(k) A dependent special enrollment period under subsection (j) of this section shall be a period of not less than 30 days and shall begin on the later of the date dependent coverage is made available, or the date of the marriage or domestic partnership, birth, or adoption or placement for adoption (as the case may be).

(l) If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(1) In the case of marriage or domestic partnership, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) In the case of a dependent's birth, as of the date of such birth; or

(3) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(Apr. 13, 1999, D.C. Law 12-209, § 307, 45 DCR 8433; Sept. 12, 2008, D.C. Law 17-231, § 27(b), 55 DCR 6758.)

Prior Codifications. — 1981 Ed., § 35-1037.

Effect of amendments. — D.C. Law 17-231, in subsecs. (k) and (l)(1), substituted “marriage or domestic partnership” for “marriage”.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

Legislative history of Law 17-231. — For Law 17-231, see notes following § 31-3301.01.

§ 31-3303.08. Disclosure of information.

(a) Any health insurer offering health insurance coverage to a small employer shall make a reasonable disclosure of the availability of information to such an employer, as part of its solicitation and sales materials, and upon request of such an employer, information concerning:

(1) The provisions of such coverage concerning the health insurer’s right to change premium rates and the factors that may affect changes in premium rates;

(2) The provisions of such coverage relating to renewability of coverage;

(3) The provisions of such coverage relating to any preexisting condition exclusion; and

(4) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(b) A health insurer is not required under this subchapter to disclose any information that is proprietary and trade secret information.

(Apr. 13, 1999, D.C. Law 12-209, § 308, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1038.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.09. Eligibility to enroll.

(a) A group health plan, and a health insurer offering group health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the health status-related factors.

(b) The provisions of this section shall not be construed to:

(1) Require a health insurer offering group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

(2) To prevent a health insurer offering group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in

the plan or coverage rules for eligibility to enroll under a plan which includes rules defining any applicable waiting periods for such enrollment.

(c) A health insurer offering group health insurance coverage may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(d) Nothing in subsection (c) of this section shall be construed to restrict the amount that an employee may be charged for coverage under group health insurance coverage, or prevent a health insurer offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(Apr. 13, 1999, D.C. Law 12-209, § 309, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1039.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.10. Exclusions.

The provisions of this subchapter shall not apply to:

(1) Any group health benefit plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees; or

(2) Any health benefit plan for any of the excepted benefits.

(Apr. 13, 1999, D.C. Law 12-209, § 310, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1040.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.11. Rules used to determine group size.

(a) All employers treated as a single employer under subsection (b), (c), (m), or (o) of § 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large group employer shall be based on the average number of

employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(c) Any reference in this section to an employer shall include a reference to any predecessor of such employer.

(Apr. 13, 1999, D.C. Law 12-209, § 311, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1041.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.12. Affiliation period.

(a) A health maintenance organization which does not impose any preexisting condition exclusion, with respect to any particular coverage option, may impose an affiliation period for such coverage option, but only if such period is applied uniformly without regard to any health status-related factors and such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(b) An affiliation period as described in subsection (a) of this section shall begin on the enrollment date.

(c) An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(Apr. 13, 1999, D.C. Law 12-209, § 312, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1042.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.13. Alternative methods.

A health maintenance organization may use alternative methods to an affiliation period to address adverse selection provided that they are approved by the Commissioner prior to their use.

(Apr. 13, 1999, D.C. Law 12-209, § 313, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1043.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

§ 31-3303.14. **Applicability.**

Unless otherwise specifically provided in this chapter, the provisions of this subchapter shall apply to group health benefit plans issued or renewed after July 1, 1997.

(Apr. 13, 1999, D.C. Law 12-209, § 314, 45 DCR 8433.)

Prior Codifications. — 1981 Ed., § 35-1044.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3301.01.

Emergency legislation. — See notes to § 31-3301.01.

Legislative history of Law 12-209. — For legislative history of D.C. Law 12-209, see Historical and Statutory Notes following § 31-3301.01.

CHAPTER 33A. HEALTH INSURANCE RATEMAKING.

Sec.	Sec.
31-3311.01. Ratemaking principles and standards.	31-3311.06. Post-claims underwriting and prior approval for rescission, cancellation, or limitation.
31-3311.02. Aggregate medical loss ratios; dividend; and rating bands.	31-3311.07. Public records.
31-3311.03. Loss ratio disclosure.	31-3311.08. Annual report and recommendations.
31-3311.04. Annual rate filing requirement.	31-3311.09. Rules.
31-3311.05. Commissioner's authority to rescind approved rates.	31-3311.10. Application.

§ 31-3311.01. Ratemaking principles and standards.

(a) All insurance premium rates and fees shall be made in accordance with the principles and standards set forth in this section. Uniformity among insurers in matters within the scope of this section shall not be required or prohibited.

(b) Due consideration shall be given to:

(1) Past and prospective loss experience within and, if necessary for actuarial credibility, outside the District;

(2) Conflagration and catastrophe hazards, if any;

(3) Past and prospective expenses, both within and, if necessary for actuarial credibility, outside the District;

(4) Underwriting profits;

(5) Contingencies;

(6) Investment income and reserve for losses as reported by the insurer in the insurer's financial statements;

(7) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders as reported by the insurer in the insurer's financial statements; and

(8) All other relevant factors within and, if necessary for actuarial credibility, outside the District.

(c) Rates or fees shall not be excessive, inadequate, or unfairly discriminatory. In determining whether rates are excessive or unfairly discriminatory, the Commissioner may consider:

(1) Historical and projected loss ratios, as described herein;

(2) Any anticipated change in the number of enrollees if the proposed premium rate is approved;

(3) Changes to cover benefits or health benefit plan design; and

(4) Changes in the insurer's health care cost and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(d) The systems of expense provisions included in the rates or fees for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to a kind of insurance or with respect to a subdivision or combination of kinds of insurance for which separate expense provisions are applicable.

(e) Except as provided for in subsection (f) of this section, for any rate filing,

the carrier shall demonstrate that the product for which the rate is filed has a target medical loss ratio of 70% or greater for individual and small group policies and 75% or greater for large group policies.

(f) The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), in his or her discretion, may approve an exemption to the target medical loss ratio set forth in subsection (e) of this section, upon receipt of justification supporting the requested exemption and after a 30-day period of public notice. Justification for a medical loss ratio of less than 70% for individual and small group policies or less than 75% for large group policies shall be based upon the following factors:

- (1) Product design or cost sharing attributes;
- (2) Expected enrollment size;
- (3) Length of time in the market;
- (4) Claims pool credibility; and
- (5) Any other relevant matter.

(Apr. 8, 2011, D.C. Law 18-360, § 102, 58 DCR 896.)

Legislative history of Law 18-360. — Law 18-360, the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", was introduced in Council and assigned Bill No. 18-792, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and

second readings on November 9, 2010, and December 7, 2010, respectively. Signed by the Mayor on January 20, 2011, it was assigned Act No. 18-710 and transmitted to both Houses of Congress for its review. D.C. Law 18-360 became effective on April 8, 2011.

§ 31-3311.02. Aggregate medical loss ratios; dividend; and rating bands.

(a) For each calendar year, an insurer shall maintain an aggregate minimum medical loss ratio, as defined by rule, of 80% for individual policies, as defined by rule, 80% for small group policies, as defined by rule, and 85% for large group policies, as defined by rule. The medical loss ratio shall be defined by the Commissioner and shall be determined by rule in a manner and generally consistent with the same standards as the medical loss ratio defined in section 2718(b) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg-18(b)). No later than May 31st of each year, insurers shall file an annual report with the Commissioner, in a manner and on a form prescribed by Commissioner, indicating the medical loss ratio calculated for all policies and contracts written for the previous calendar year.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this chapter when combined with actual experience to date.

(c) In each case where the insurer fails to substantially comply with the medical loss ratio requirements set forth in subsection (a) of this section, the insurer shall issue a rebate for all policyholders in an amount determined in accordance with section 2718(b)(1)(B) of the Public Health Service Act, approved March 23, 2010 (124 Stat. 136; 42 U.S.C. § 300gg-18(b)(1)(B)). The annual report required by this section shall include the insurer's calculation of the rebates and an explanation of the insurer's plan to issue rebates. The

instructions and format for calculating and reporting medical loss ratios and issuing rebates shall be prescribed by the Commissioner by rule. The Commissioner shall establish, by rule, procedures for the distribution of a rebate in the event of cancellation or termination by a policyholder.

(d) A plan of individual or small group health insurance rates shall not include a standard rate for any age that is more than 300% of the standard rate for the age with the lowest rate in the same plan and the standard rate for any age shall not be more than 104% of the standard rate for the previous age.

(e) An insurer's failure to comply with the rebate requirements in subsection (c) of this section or rating band requirements set forth in subsection (d) of this section shall constitute an unfair or deceptive act or practice and shall be subject to the penalties in Chapter 22A of this title [§ 31-2231.01 et seq.].

(f) The Commissioner may audit any insurer to assure compliance with this section. Insurers shall retain at their principal place of business information necessary for the Commissioner to perform compliance audits.

(Apr. 8, 2011, D.C. Law 18-360, § 103, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

in subsec. (b), is D.C. Law 18-360, the Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010.

References in text. — This act, referred to

§ 31-3311.03. Loss ratio disclosure.

Policies, certificates, and marketing materials shall prominently display medical loss ratio disclosure, as defined by rule.

(Apr. 8, 2011, D.C. Law 18-360, § 104, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.04. Annual rate filing requirement.

All insurers subject to this chapter shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy form or certificate form, for approval by the Commissioner. The supporting documentation shall demonstrate, in accordance with actuarial principles and standards, using reasonable assumptions, that the appropriate medical loss ratio standards can be expected to be met over the entire period for which rates are computed and that insurer is in compliance with the ratemaking principles of this chapter. If the data submitted does not confirm that the insurer has satisfied the requirements of this chapter, the Commissioner shall notify the insurer in writing of the deficiency within 30 business days of the date that the data is submitted. The insurer shall have 30 days after the date of the Commissioner's notice to file amended rates that comply with this chapter. If the insurer fails to file amended rates within the 30-day period, the Commissioner shall order that the insurer's filed rates for the nonconforming policies and certificates be reduced to an amount

that would bring the rates into compliance with this chapter. Upon request of the insurer and before any order or notice issued pursuant to this section becomes final, the Commissioner shall hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing. The insurer's failure to file amended rates within the specified time or the issuance of the Commissioner's order amending the rates shall not preclude the insurer from filing an amendment of its rates at a later time.

(Apr. 8, 2011, D.C. Law 18-360, § 105, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.05. Commissioner's authority to rescind approved rates.

(a) The Commissioner may, at any time, require any insurer subject to this chapter to demonstrate that its rates and method for setting rates are in compliance with this chapter, notwithstanding that the filings then in effect had previously been approved. Any rates previously approved by the Commissioner, but subsequently disapproved under this chapter, shall be considered disapproved on a prospective basis only from the date of the notice of disapproval, unless the insurer made a material misrepresentation in its contract form or rate filings, in which case the rates shall be deemed disapproved on a retroactive basis.

(b) If, at any time subsequent to the approval of rates, the Commissioner finds that a filing does not meet the requirements of this chapter, the Commissioner shall issue an order to the insurer specifying why the filing fails to meet the requirements of this chapter, and, stating when, within a reasonable period thereafter, the filing shall be no longer effective. The order shall not affect any subscriber contract, group certificate, or other contract made or issued prior to the expiration of the period set forth in the order. The Commissioner may, prior to issuing the order and if requested by the insurer, hold a hearing upon not less than 10 business days' written notice to the insurer specifying the matters to be considered at the hearing.

(c) For violations of this chapter, the Commissioner may order any relief which is appropriate, including disapproving a rate and awarding interest.

(Apr. 8, 2011, D.C. Law 18-360, § 106, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

References in text. — This act, referred to

in subsec. (b), is D.C. Law 18-360, the Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010.

§ 31-3311.06. Post-claims underwriting and prior approval for rescission, cancellation, or limitation.

(a) An insurer shall not rescind an enrollee's plan or coverage once the enrollee is covered under the plan or coverage involved; provided, that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage shall not be cancelled without prior notice to the Commissioner as required by subsection (b) of this section and prior notice to the consumer and an opportunity to appeal as required by the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 109; scattered sections of the United States Code).

(b) A health carrier shall provide at least 30 days advance written notice to each plan enrollee, or for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) of this section regardless of, in the case of group or only to an individual within the group. The notice shall explain the reason for the rescission, procedures of appealing, and how to contact the Health Care Ombudsman and the Department of Insurance, Securities, and Banking for further information.

(c) Prior to rescinding the enrollee's plan or coverage, the insurer shall provide to the Commissioner documentation to support the rescission and the Commissioner shall have 5 business days following receipt of the proposed rescission and supporting documentation to review the documentation to determine if the insurer is complying with the requirements of subsection (a) of this section. The insurer may rescind the plan or coverage after the end of the 5-day period of review unless the Commissioner objects or disapproves the proposed rescission within the 5-day period.

(Apr. 8, 2011, D.C. Law 18-360, § 107, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.07. Public records.

The Commissioner shall, as soon as practicable, make all rate filings, including all supporting documentation, amended filings, and reports filed pursuant to this chapter, available for public inspection either at the Department of Insurance, Securities, and Banking or on its website.

(Apr. 8, 2011, D.C. Law 18-360, § 108, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.08. Annual report and recommendations.

On June 1, 2011, and every year thereafter, the Commissioner shall report to the Council any significant National Association of Insurance Commissioners adoptions related to health care reform, including medical loss ratios and loss ratio disclosure, and any recommendations if the District law differs.

(Apr. 8, 2011, D.C. Law 18-360, § 109, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.09. Rules.

The Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of this chapter.

(Apr. 8, 2011, D.C. Law 18-360, § 110, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

§ 31-3311.10. Application.

This chapter shall apply to policies and certificates of insurance that are health benefit plans as defined under § 31-3271(4) that are issued 90 days after April 8, 2011. This chapter shall not apply to short-term limited duration health benefit plans.

(Apr. 8, 2011, D.C. Law 18-360, § 111, 58 DCR 896.)

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-3311.01.

CHAPTER 34. HEALTH MAINTENANCE ORGANIZATIONS.

Sec.	Sec.
31-3401. Definitions.	31-3417. Powers of insurance corporations.
31-3402. Establishment of health maintenance organizations.	31-3418. [Repealed].
31-3403. Issuance of certificate of authority.	31-3419. Suspension or revocation of certificate of authority.
31-3403.01. Premium tax.	31-3420. Rehabilitation, liquidation, or conservation of health maintenance organizations.
31-3404. Powers of health maintenance organizations.	31-3421. Summary orders and supervision.
31-3405. Fiduciary responsibilities.	31-3422. Regulations.
31-3406. Quality assurance program.	31-3423. Penalties and enforcement.
31-3407. Requirements for group contract, individual contract, and evidence of coverage.	31-3424. Statutory construction and relationship to other laws.
31-3408. [Repealed].	31-3425. Filings and reports as public documents.
31-3408.01. Compliance with other laws.	31-3426. Confidentiality of medical information and limitation of liability.
31-3409. Information to enrollees.	31-3427. Acquisition of control of or merger of a health maintenance organization.
31-3410. [Repealed].	31-3428. [Repealed].
31-3411. Investments.	31-3429. Point of service plan.
31-3412. Protection against insolvency.	31-3430. Insolvency protection; assessment.
31-3413. Uncovered expenditures insolvency deposit.	31-3431. Principal office, books, records, and files of the health maintenance organization to be in the District.
31-3414. Enrollment period; replacement coverage in the event of insolvency.	
31-3415. Filing requirements for rating information.	
31-3416. Regulation of health maintenance organization producers.	

§ 31-3401. Definitions.

For the purposes of this chapter, the term:

(1) "Administrative services provider contract" means a contract entered into between a health maintenance organization and a contracting provider in which the contracting provider accepts payments for certain covered services provided to the enrollees of the health maintenance organization by external providers, and the contracting provider pays the external providers pursuant to a contract between the contracting provider and the health maintenance organization.

(2) "Agent" means a person who solicits, negotiates, effects, procures, delivers, renews, or continues a contract for health maintenance organization membership, other than for himself, or a person who advertises or otherwise holds himself out to the public as such. Health maintenance organization agents shall not include salaried employees and officers of the HMO or its parents, subsidiaries or other corporations under common control with the HMO, whose principal duties do not include the negotiation or solicitation of enrollee contracts.

(3) "Basic health care services" means preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services, and services mandated under Chapter 29 of this title, Chapter 31 of this title, and Chapter 38 of this title.

(4) "Capitated basis" means fixed per member per month payment or percentage of dues payment wherein the provider or an affiliation of providers

assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For the purposes of this definition, the term "capitated basis" includes the cost associated with operating staff or group model facilities.

(5) "Carrier" means a health maintenance organization, a licensed insurer, Group Hospitalization and Medical Services, Inc., or other entity responsible for payment of benefits or provision of services under a group or individual contract.

(6) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(7) "Contracting provider" means a physician or other health care provider who enters into an administrative service provider contract with a health maintenance organization.

(8) "Copayment" means either a dollar or percentage amount an enrollee must pay in order to receive a specific covered service which is not fully prepaid.

(9) "Covered services" means health care services included in the health maintenance organization's evidence of coverage in accordance with the terms of the health maintenance organization's group or individual contract.

(10) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(11) "Director" means the Director of the Department of Health, established by Reorganization Plan No. 4 of 1996.

(12) "District" means the District of Columbia.

(13) "Enrollee" means an individual who is covered by a health maintenance organization.

(14) "Enrollment fees" means the payment charged by the health maintenance organization which shall be paid by an enrollee or by a group on behalf of enrollees for coverage in the health maintenance organization.

(15) "Evidence of coverage" means a statement of the essential features and covered services of the health maintenance organization which is given to the enrollee by the health maintenance organization or by the group contract holder.

(16) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is hospitalized on the date of termination.

(17) "External provider" means a health care provider, including a physician or hospital, that is not a contracting provider, or an employee, shareholder, or partner of a contracting provider.

(18) Repealed.

(19) "Group contract" means a contract issued and delivered in the District for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

(20) "Group contract holder" means the person to which the group contract has been issued.

(21) "Health maintenance organization" or "HMO" means any person that undertakes to provide or arrange for the delivery of basic health care services

to enrollees on a prepaid basis, except for enrollee responsibility for copayments and deductibles.

(22) "Health maintenance organization producers" means any person who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for HMO membership or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

(23) "Hold harmless" means an expressed or implied arrangement between a provider and a health maintenance organization by which the provider, or any representative of the provider, agrees not to collect or attempt to collect from any enrollee any money owed to the provider by the health maintenance organization or by a contracting provider, except for copayments and deductibles owed by the enrollee, or any payment or charges for health care services not covered under the evidence of coverage.

(24) "Individual contract" means a contract delivered in the District for health care services issued to and covering an individual enrollee. The individual contract may include dependents of the enrollee.

(25) "Insolvent" or "insolvency" means that the organization has been declared bankrupt and placed under an order of liquidation by a court of competent jurisdiction.

(26) "Mayor" means the Mayor of the District of Columbia.

(27) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

(28) "Participating provider" means a provider who, under an express or implied contract with a health maintenance organization or with its contractor or subcontractor, has agreed to provide covered services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

(29) "Person" means any natural or artificial person, including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

(30) "Point of service plan" means a delivery system that permits an enrollee of a health maintenance organization to receive services outside the provider panel of the health maintenance organization under the terms and conditions of the enrollee's contract with the health maintenance organization.

(31) "Primary care provider" means a participating provider who the enrollee has selected or who has otherwise been assigned responsibility for the coordination of covered services to the enrollee.

(32) "Provider" means any hospital or health professional licensed or authorized by reciprocity or endorsement to practice a health occupation by the District pursuant to Chapter 12 of Title 3, or any state.

(33) "Provider panel" means a group of providers that have entered into a written provider service contract with an HMO to provide services under the HMO's health benefit plan.

(34) "Replacement coverage" means the benefits provided by a succeeding carrier after termination of a member's enrollment with the preceding carrier.

(35) "Uncovered expenditures" means the cost to the health maintenance organization for covered services that are the obligation of the health mainte-

nance organization for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the Commissioner.

(Apr. 9, 1997, D.C. Law 11-235, § 2, 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 46(a), 45 DCR 745; Apr. 27, 1999, D.C. Law 12-274, § 501(a)(1), 46 DCR 1294; June 11, 2004, D.C. Law 15-166, § 4(t), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4501.

Effect of amendments. — D.C. Law 15-166, in par. (6), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Temporary Addition of Section. — Section 101 to 106 of D.C. Law 18-271 added sections to read as follows:

"Sec. 101. Establishment of the DC High Risk Pool Program.

"(a) There is established the DC High Risk Pool Program ('Program'), which shall provide affordable health insurance benefits to eligible individuals.

"(b) The Program shall be:

"(1) Administered by the Department of Health Care Finance, established by the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.01 et seq.);

"(2) Funded through federal funds made available through the temporary high risk pool program, established by the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001) ('federal act'), and administered by the U.S. Department of Health and Human Services;

"(3) Subject to the availability of funding; and

"(4) Expire on December 31, 2013; provided, that federal requirements or contractual obligations between the District and the U.S. Department of Health and Human Services do not necessitate a different date.

"(c) Nothing in this section shall be construed to create or constitute an entitlement to health insurance or to health or medical benefits.

"Sec. 102. Program eligibility.

"An individual shall be eligible for the Program if the individual:

"(1) Is a District resident;

"(2) Is a United States citizen, or lawfully in the country;

"(3) Has not had creditable health coverage for the 6 months prior to applying for the Program;

"(4) Has one or more pre-existing conditions that have resulted in the inability to obtain commercial insurance coverage on the individual market; and

"(5) Is not eligible for public health-insurance benefits.

"Sec. 103. Program benefits.

"The Program shall provide comprehensive coverage for services that meet the requirements of the temporary high risk pool program, established by the federal act.

"Sec. 104. Affordability of coverage.

"Under the Program:

"(1) The premium levels charged to enrollees shall be no greater than 100% of the standard risk rate for each age group, with a variability no greater than 4-to-1 between any 2 age groups;

"(2) The out-of-pocket limit of coverage for cost-sharing for the required benefits shall not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986, approved December 8, 2003 (117 Stat. 2469; 26 U.S.C. § 223(c)(2)), for the year involved; and

"(3) There shall not be any annual or lifetime dollar limits on any service, including prescription drugs.

"Sec. 105. Program implementation.

"To meet the deadline set by the U.S. Department of Health and Human Services, the Mayor is authorized to enter into a contract with a qualified insurer or hospital and medical services corporation licensed in the District.

"Sec. 106. Rules.

"The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 et seq.), shall issue rules to implement the provisions of this title."

Section 302(b) of D.C. Law 18-271 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(t) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) additions, see §§ 101 to 106 of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18-522, August 3, 2010, 57 DCR 8001).

Legislative history of Law 11-235. — Law 11-235, the "Health Maintenance Organization Act of 1996," was introduced in Council and assigned Bill No. 11-442, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-495 and transmitted to both Houses of Congress for its review. D.C. Law 11-235 became effective on April 9, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 12-274. — Law 12-274, the “Health Benefits Plan Members Bill of Rights Act of 1998,” was introduced in Council and assigned Bill No. 12-501. The Bill was adopted on first and second reading on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 29, 1998, it was assigned Act No. 12-607, and transmitted to both Houses of Congress for review. D.C. Law 12-274 became effective on April 27, 1999.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Editor’s notes. — Application of D.C. Law 12-274: Section 501(b) of D.C. Law 12-274 provided that this section shall apply upon the promulgation of regulations pursuant to § 32-574.1 (§ 44-304.01, 2001 Ed.).

§ 31-3402. Establishment of health maintenance organizations.

(a) Any person may apply to the Commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in the District without obtaining a certificate of authority under this chapter, except as provided for herein. Any person who shall establish and operate a health maintenance organization without obtaining a certificate of authority shall be prohibited from receiving a certificate of authority to do business as a health maintenance organization for a period not to exceed 5 years as determined by the Commissioner. All health maintenance organizations shall, as a condition of certification, agree to accept the risk for the provision of services rendered to enrollees on a prepaid basis except for enrollee responsibility for copayments or deductibles, or both.

(b) A foreign corporation may qualify under this chapter subject to its registration to do business pursuant to this section and compliance with all provisions of this chapter and other applicable District laws.

(c) All health maintenance organizations operating as health maintenance organizations in the District shall submit an application for a certificate of authority under subsection (d) of this section within 120 days after April 9, 1997. Each applicant may continue to operate until the Commissioner acts upon the application. In the event that an application is denied pursuant to § 31-3403, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked. Notwithstanding a revocation under this chapter, any contracts issued to groups or individuals residing in the District shall remain in effect with respect to a health maintenance organization which has a valid certificate of authority issued by the Maryland Insurance Division or Virginia Bureau of Insurance until the next renewal date or anniversary date of coverage of such contracts, or 120 days from the date the application is denied, whichever date shall occur later.

(d) Each application for a certificate of authority shall be accompanied by a filing fee of \$500, which shall be deposited in the Insurance Regulatory Trust

Fund established by § 31-1202, and shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions and biographical information, on forms acceptable to the Commissioner, of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of partnership or association;

(4) A sample of any contract form made, or to be made, between any class of providers and the health maintenance organization and a copy of any contract form made, or to be made, between third party administrators, marketing consultants, or persons listed in paragraph (3) of this subsection and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, including both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

(8)(A) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining dues to be charged during the first 12 months of operations certified by an actuary, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the District, and income and expense statements anticipated from the start of operations until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other sources of funding.

(B) The requirement of submitting a financial feasibility plan shall not apply to any person that holds an unencumbered certificate of authority to operate a health maintenance organization in Maryland or Virginia.

(9) A power of attorney duly executed by the applicant, if not domiciled in the District, appointing the Commissioner, or his or her successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for the District upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in the District may be served;

(10) A statement or map reasonably describing the geographical area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in § 31-3412;

(14) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

(15) The method of determining the situs of each group contract; and

(16) Such other information as the Commissioner may require to make the determinations required in § 31-3403.

(e)(1) The Commissioner may issue rules and regulations necessary for the proper administration of this chapter to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modification, or amendments to the items described in subsection (d) of this section to the Commissioner, either for the Commissioner's approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to the Commissioner at the time of the next succeeding site visit or examination.

(2) Any modification or amendment for which the Commissioner's approval is required shall be deemed approved unless disapproved within 30 days, provided that the Commissioner may postpone the action for such additional time, not to exceed 30 days, as necessary for proper consideration.

(Apr. 9, 1997, D.C. Law 11-235, § 3, 44 DCR 818; Mar. 27, 2003, D.C. Law 14-252, § 2(a), 50 DCR 225.)

Section references. — This section is referred to in § 31-3412.

Prior Codifications. — 1981 Ed., § 35-4502.

Effect of amendments. — D.C. Law 14-252, in subsec. (a), added the third sentence.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — Law 14-252, the "Health Maintenance Organization Amendment Act of 2002", was introduced in Council and assigned Bill No. 14-156, which

was referred to the Committee on Human Services. The Bill was adopted on first and second readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 23, 2002, it was assigned Act No. 14-549 and transmitted to both Houses of Congress for its review. D.C. Law 14-252 became effective on March 27, 2003.

Editor's notes. — Application of Law 14-252: Section 3 of D.C. Law 14-252 provided: "This act shall not apply until the Commissioner gives written notice that all necessary rules and administrative procedures are in place to effect the provisions of this act."

§ 31-3403. Issuance of certificate of authority.

(a) Upon receipt of an application for issuance of a certificate of authority, the Commissioner, in consultation with the Director of the Department of Health, shall determine whether the applicant, with respect to the health care services to be provided, has complied with § 31-3406.

(b) Within 45 days of receipt of the application for issuance of a certificate of authority, the Commissioner, in consultation with the Director of the Depart-

ment of Health, shall certify that the proposed health maintenance organization meets the requirements of § 31-3406 or notify the applicant that it does not meet such requirements and specify in what respects it is deficient.

(c) The Commissioner shall issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the Commissioner being satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) Any deficiencies identified by the Commissioner have been corrected and the health maintenance organization's proposed plan of operation meets the requirements of § 31-3406;

(3) The health maintenance organization will effectively provide or arrange for basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

(4) The health maintenance organization is in compliance with §§ 31-3412 and 31-3414.

(d) A certificate of authority may be denied only after the Commissioner complies with the requirements of § 31-3419.

(e) The Commissioner, in carrying out his obligations under this chapter, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Recommendations may be accepted in full or in part by the Commissioner.

(f) Repealed.

(g) Repealed.

(h) Each certificate of authority to do business in the District of Columbia shall renew on May 1 of each year following the date of its issuance unless it has been revoked or the renewal fee under subsection (h) of this section has not been paid.

(i) The Commissioner may charge a renewal license fee to health maintenance organizations licensed to do business in the District of Columbia. The renewal fee shall be paid before April 2 of each renewal year. The fee shall be remitted in a manner prescribed by the Commissioner.

(j) After receiving its certificate of authority, a health maintenance organization shall submit to the Commissioner information concerning any modification or amendment to its application for a certificate of authority or supporting documentation prior to the effectuation of the modification or amendment or provide this information or documentation to the Commissioner when the health maintenance organization files its annual report.

(Apr. 9, 1997, D.C. Law 11-235, § 4, 44 DCR 818; Oct. 21, 2000, D.C. Law 13-190, § 4(a), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 604(a), 49 DCR 6968; Mar. 27, 2003, D.C. Law 14-252, § 2(b), 50 DCR 225; Mar. 2, 2007, D.C. Law 16-191, §§ 66, 134, 53 DCR 6794; Mar. 8, 2007, D.C. Law 16-232, § 204(a), 54 DCR 368.)

Section references. — This section is referred to in §§ 31-3402 and 31-3419.

Prior Codifications. — 1981 Ed., § 35-4503.

Effect of amendments. — D.C. Law 13-190 added subsec. (f).

D.C. Law 14-190 added subsec. (g).

D.C. Law 14-252 added subssecs. (h), (i), and (j).

D.C. Law 16-191 validated previously made technical corrections in the designations of subssecs. (h) to (j).

D.C. Law 16-232 repealed subssecs. (f) and (g), which formerly read:

“(f) A health maintenance organization may, at its own option and expense, submit a statement from an independent organization acceptable to the Commissioner, attesting that it meets all the requirements of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority. The statement shall be signed, under oath, by an officer or principal of the independent organization and shall be considered prima facie evidence by the Commissioner that the health maintenance organization is entitled to do business in the District, subject to (1) an investigation and review, and (2) the Commissioner’s authority to revoke or suspend a certificate of authority as provided in this chapter.

“(g) A health maintenance organization may, at its option, submit a certified copy of its current certificate of authority to do business from the jurisdiction where it is organized (‘home jurisdiction’) and from the jurisdiction where it conducts its largest volume of business (‘largest volume jurisdiction’), if different than its home jurisdiction, together with a statement by a corporate officer that it meets all the requirements of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority; provided, that the health maintenance organization’s home jurisdiction and largest volume jurisdiction have been determined by the Commissioner to have legal and regulatory requirements that meet or exceed those applicable to insurance companies under District law. The statement of the corporate officer shall be signed, under oath, and shall, together with certified copies of the health maintenance organization’s certificates of authority, be considered prima facie evidence by the Commissioner that the health maintenance organization is entitled to do business in the District. Nothing in the preceding sentence shall limit the Commissioner’s authority to subject the applicant to investigation and review or to suspend a certificate of authority as provided in this chapter. As a condition of obtaining a certificate of authority to do business in the District of Columbia, the Commissioner may also require a health maintenance organization submitting a certificate of authority from an alien jurisdiction to submit a power of attorney and undertaking, in a form acceptable to the Commissioner, that

provide that the health maintenance organization will not set up a defense to any claim, action, or proceeding brought against it arising from an insurance contract entered into in the District of Columbia, nor refuse to obey any lawful order of the Commissioner, or pay any fine or penalty imposed upon it by the Commissioner or any court of competent jurisdiction, on the ground that it is not subject to the laws of the United States of America or the District of Columbia. The Commissioner shall publish annually in the District of Columbia Register a list of foreign and alien jurisdictions that have been determined by the Commissioner as having legal and regulatory requirements that meet or exceed those applicable to insurance companies under District law. The Commissioner may at any time add or remove jurisdictions from the list and the additions and deletions shall be effective immediately until the next annual publication date.”

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of TANF-Related Medicaid Managed Care Program Temporary Amendment Act of 1998 (D.C. Law 12-141, July 24, 1998, law notification 45 DCR 6512).

Emergency legislation. — For temporary amendment of section, see § 2 of the TANF and TANF-Related Medicaid Managed Care Program Emergency Amendment Act of 1998 (D.C. Act 12-311, March 26, 1998, 45 DCR 2124), and § 2 of the TANF and TANF-Related Medicaid Managed Care Program Legislative Review Emergency Amendment Act of 1998 (D.C. Act 12-366, June 5, 1998, 45 DCR 4039).

For temporary (90 day) amendment of section, see § 604(a) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 13-190. — Law 13-190, the “Insurer and Health Maintenance Organization Self-Certification Act of 2000,” was introduced in Council and assigned Bill No. 13-722, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 2, 2000, it was assigned Act No. 13-407 and transmitted to both Houses of Congress for its review. D.C. Law 13-190 became effective on October 21, 2000.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

§ 31-3403.01. Premium tax.

(a) Effective January 1, 2009, all health maintenance organizations shall pay to the District of Columbia, for each calendar year, a sum of money as taxes equal to 2% of their policy and membership fees and net premium receipts or consideration received in such calendar year, excluding those fees, receipts, or consideration received pursuant to any federal employee health-benefit program or Medicare, on all policies or contracts in the District of Columbia. The premium tax shall be in lieu of all other taxes except:

- (1) Taxes upon real estate; and
- (2) Fees and charges provided for pursuant to this chapter.

(b) The certificate of authority of any health maintenance organization may be revoked for failure to pay the required premium tax.

(c) All revenues generated pursuant to this section shall be collected in a manner prescribed by the Mayor.

(d) Any revenues generated from this section arising from contracts for services under the District's Medicaid program, DC HealthCare Alliance program, or Healthy DC program shall be deposited in the Healthy DC and Health Care Expansion Fund, established by § 31-3514.02.

(e) Of all other revenues generated pursuant to this section, 75% shall be deposited in the Healthy DC and Health Care Expansion Fund and 25% shall be deposited in the General Fund of the District of Columbia.

(f) For the purposes of this section, the term, "health maintenance organization" shall include prepaid health plans.

(Apr. 9, 1997, D.C. Law 11-235, § 4a, as added Aug. 16, 2008, D.C. Law 17-219, § 5054, 55 DCR 7598; Feb. 4, 2010, D.C. Law 18-104, § 4(b), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18-223, § 5022, 57 DCR 6242.)

Effect of amendments. — D.C. Law 18-104, in subsec. (a-1), substituted "District Medicaid program, the Healthy DC Program," for "District Medicaid program."

D.C. Law 18-223, in subsec. (a), deleted "the District Medicaid Program, the Healthy DC Program, the DC HealthCare Alliance," following "pursuant to"; rewrote subsec. (d); and added subssecs. (e) and (f). Prior to amendment, subsec. (d) read as follows: "(d) Seventy-five percent of the revenue generated pursuant to this section shall be deposited in the Healthy DC Fund, established by § 31-3514.02. The remaining 25% shall be deposited in the General Fund of the District of Columbia."

Temporary Amendment of Section. — Section 4(b) of D.C. Law 18-134 substituted "District Medicaid program, the Healthy DC Program," for "District Medicaid program."

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Section 2 of D.C. Law 18-205, in subsec. (a), deleted "the District Medicaid Program, the Healthy DC Program, the DC HealthCare Alliance,"; rewrote subsec. (d) to read as follows:

"(d) Any revenues generated from this section arising from contracts for services under the District's Medicaid program, DC HealthCare Alliance program, or Healthy DC program shall be deposited in the Healthy DC and Health Care Expansion Fund, established by section 15b of the Hospital and Medical Services Corporation Regulatory Act of 1996, effective March 2, 2007 (D.C. Law 16-192; D.C. Official Code § 31-3514.02)."; and added subssecs. (e) and (f) to read as follows:

"(e) Of all other revenues generated pursuant to this section, 75% shall be deposited in the Healthy DC and Health Care Expansion Fund and 25% shall be deposited in the General Fund of the District of Columbia.

"(f) For the purposes of this section, the term, 'health maintenance organization' shall include prepaid health plans."

Section 7(b) of D.C. Law 18-205 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(b) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 2 of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18-390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5022 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 17-219. — Law 17-219, the “Fiscal Year 2009 Budget Support Act of 2008”, was introduced in Council and

assigned Bill No. 17-678, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 13, 2008, and June 3, 2008, respectively. Signed by the Mayor on June 26, 2008, it was assigned Act No. 17-419 and transmitted to both Houses of Congress for its review. D.C. Law 17-219 became effective on August 16, 2008.

Legislative history of Law 18-104. — For Law 18-104, see notes following § 31-205.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

Short title. — Short title: Section 5053 of D.C. Law 17-219 provided that subtitle U of title V of the act may be cited as the “Healthy DC Revenue Amendment Act of 2008”.

Short title: Section 5021 of D.C. Law 18-223 provided that subtitle C of title IV of the act may be cited as the “Medicaid Resource Maximization Amendment Act of 2010”.

§ 31-3404. Powers of health maintenance organizations.

(a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property and equipment as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, enrollee, etc.) between affiliates or between the health maintenance organization and its parent;

(3) The furnishing of health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) The contracting with any person for the performance on its behalf of certain functions, such as marketing, enrollment, and administration;

(5) The contracting with an insurance company, including Group Hospitalization and Medical Service, Inc., licensed in the District for the provision of insurance, indemnity, or reimbursement against the cost of covered services provided by the health maintenance organization or with optometry services, podiatry services, dental services, pharmaceutical service plans, and other entities authorized to do business in the District for the provision of supplemental health services;

(6) The joint marketing of products with an insurance company authorized to do business in the District as long as the company that is offering each product is clearly identified; and

(7) Entering into administrative service provider contracts with contracting providers whereby covered services are rendered to enrollees by external providers who have entered into contracts with the contracting provider.

(b) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any

power granted in subsection (a)(1), (2), or (4) of this section which may affect the financial soundness of the health maintenance organization. The Commissioner shall disapprove such exercise of power only if the Commissioner determines it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner does not disapprove within 30 days of the filing of the notice, the exercise of power shall be deemed approved.

(c) The Commissioner may issue rules and regulations exempting those activities having a de minimis effect from the filing requirement of this subsection.

(Apr. 9, 1997, D.C. Law 11-235, § 5, 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 46(b), 45 DCR 745.)

Section references. — This section is referred to in § 31-3411.

Prior Codifications. — 1981 Ed., § 35-4504.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see His-

torical and Statutory Notes following § 31-3401.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-3401.

§ 31-3405. Fiduciary responsibilities.

(a) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors, and partners in an amount not less than \$250,000 and not more than \$5,000,000.

(Apr. 9, 1997, D.C. Law 11-235, § 6, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4505.

Legislative history of Law 11-235. — For

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

§ 31-3406. Quality assurance program.

(a) A health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) A health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

- (1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;
- (2) A written quality assurance plan which describes the following:

(A) The health maintenance organization's scope and purpose in quality assurance;

(B) The organizational structure responsible for quality assurance activities;

(C) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(D) Confidentiality policies and procedures;

(E) A system of ongoing evaluation activities;

(F) A system of focused evaluation activities;

(G) A system for credentialing providers and performing peer review activities; and

(H) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system on ongoing quality assurance activities including:

(A) Problem assessment, identification, selection, and study;

(B) Corrective action, monitoring, evaluation, and reassessment; and

(C) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been provided have not been provided.

(c) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the Commissioner.

(d) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the Commissioner.

(f) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate staff.

(g) If a quality assurance program has received approval in Maryland or Virginia, or if a quality assurance program has been approved by the D.C. Medicaid Program, it shall be deemed approved.

(h) The following shall apply to health maintenance organizations, carriers, and providers:

(1) No contract between a health maintenance organization and a provider shall prohibit, impede, or interfere in the discussions between a patient

and a provider of medical treatment option including discussions regarding financial coverage of those treatment options.

(2) A contract between a carrier and a provider shall permit and require the provider to discuss medical treatment options with the patient.

(3) A health maintenance organization may not terminate or refuse to contract with a provider solely because the provider discussed medical treatment options with an enrollee.

(i) The Commissioner may accept all or part of a quality assurance report and supporting documentation of an approved accrediting organization acceptable to the Commissioner to satisfy the review requirements under this section; provided, that such acceptance shall not preclude the Commissioner from performing the examination function.

(j) The expense of the quality assurance examination shall be borne by the entity applying for the health maintenance organization certificate of authority or otherwise seeking to comply with this section.

(Apr. 9, 1997, D.C. Law 11-235, § 7, 44 DCR 818; Mar. 27, 2003, D.C. Law 14-252, § 2(c), 50 DCR 225.)

Section references. — This section is referred to in §§ 31-3403 and 31-3426.

Prior Codifications. — 1981 Ed., § 35-4506.

Effect of amendments. — D.C. Law 14-252 added subsecs. (i) and (j).

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

§ 31-3407. Requirements for group contract, individual contract, and evidence of coverage.

(a) Every group and individual contract holder is entitled to a group or individual contract.

(1) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation.

(2) The contract shall contain a clear statement of the following:

- (A) Name and address of the health maintenance organization;
- (B) Eligibility requirements;
- (C) Covered services within the service area;
- (D) Covered emergency care benefits and services;
- (E) Out of area covered benefits and services, if any;
- (F) Copayments, deductibles, or other out-of-pocket expenses;
- (G) Limitations and exclusions;
- (H) Enrollee termination;
- (I) Enrollee reinstatement, if any;
- (J) Claims procedures;
- (K) Repealed.
- (L) Continuation of coverage, if any;
- (M) Conversion;
- (N) Extension of benefits if any;
- (O) Coordination of benefits, if applicable;

- (P) Subrogation, if any;
- (Q) Description of the service area;
- (R) Entire contract provision;
- (S) Term of coverage;
- (T) Cancellation of group or individual contract holder;
- (U) Renewal;
- (V) Reinstatement of group or individual contract holder, if any;
- (W) Grace period;
- (X) Conformity with District of Columbia law; and
- (Y) Payment provisions.

(3) An evidence of coverage may be filed as part of the group contract to describe the provisions required in paragraph (2)(A) through (Q) of this subsection.

(b) In addition to the requirements of subsection (a)(2)(A) through (Y) of this section, an individual contract shall provide for a 10-day period to examine and return the contract and have the dues refunded. If services were received during the 10-day period and the person returns the contract to receive a refund of the dues paid, the person must pay for such services.

(c) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(1) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, or deceptive.

(2) The evidence of coverage shall contain a clear statement of the requirements in subsection (a)(2)(A) through (Q) of this section.

(d) The Commissioner may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

(e) No group or individual contract, evidence of coverage, or amendment thereto shall be delivered or issued for delivery in the District unless its form has been filed with and approved by the Commissioner pursuant to subsections (f) and (g) of this section.

(f) If an evidence of coverage issued pursuant to a contract issued in the District is intended for delivery in the District, the evidence of coverage must be submitted to and approved by the Commissioner in accordance with subsection (g) of this section.

(1) If an evidence of coverage issued pursuant to a contract issued in Virginia or Maryland is intended for delivery in the District, the evidence of coverage shall be deemed approved if it has been filed and approved by the appropriate regulatory authority of Virginia or Maryland, as applicable.

(2) If an evidence of coverage issued pursuant to a contract issued in another state, excepting Virginia and Maryland as described in paragraph (1) of this subsection, is intended for delivery in the District, the evidence of coverage must be submitted to and approved by the Commissioner in accordance with subsection (g) of this section.

(g) Every form required by this section shall be filed with the Commissioner not less than 30 days prior to delivery or issue for delivery in the District. At any time during the initial 30-day period, the Commissioner may extend the period for review for an additional 30 days. Notice of an extension shall be in

writing. At the end of the review period, the form is deemed approved if the Commissioner has taken no action. The filer shall notify the Commissioner in writing prior to using a form that is deemed approved.

(1) At any time, after 30-days notice and for cause shown, the Commissioner may withdraw approval of any form effective at the end of the 30 days if the form would violate a statute or regulation of the District. For group and individual contracts and evidence of coverages which have already been issued and delivered, the effective date shall not occur until the next anniversary date of the group or individual contract unless the Commissioner requires that the effective date shall be earlier. In such case, the health maintenance organization may revise its dues and other terms contained in the contract or evidence of coverage to reflect any changes required as a result of the Commissioner's withdrawal of approval.

(2) When a filing is disapproved or approval of a form is withdrawn, the Commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within 30 days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within 30 days after the Commissioner has received the request for a hearing.

(h) The Commissioner may require the submission of any relevant information the Commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(Apr. 9, 1997, D.C. Law 11-235, § 8, 44 DCR 818; Apr. 27, 1999, D.C. Law 12-274, § 501(a)(2), 46 DCR 1294.)

Section references. — This section is referred to in § 31-3419.

Prior Codifications. — 1981 Ed., § 35-4507.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-274. — For

legislative history of D.C. Law 12-274, see Historical and Statutory Notes following § 31-3401.

Editor's notes. — Application of D.C. Law 12-274: Section 501(b) of D.C. Law 12-274 provided that this section shall apply upon the promulgation of regulations pursuant to § 32-574.1 (§ 44-304.01, 2001 Ed.).

§ 31-3408. Annual report. [Repealed].

Repealed.

(Apr. 9, 1997, D.C. Law 11-235, § 9, 44 DCR 818; Apr. 27, 1999, D.C. Law 12-274, § 501(a)(3), 46 DCR 1294; Mar. 27, 2003, D.C. Law 14-252, § 2(d), 50 DCR 225.)

Prior Codifications. — 1981 Ed., § 35-4508.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-274. — For

legislative history of D.C. Law 12-274, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

Editor's notes. — Application of D.C. Law 12-274: Section 501(b) of D.C. Law 12-274 pro-

vided that this section shall apply upon the promulgation of regulations pursuant to § 32-574.1 (§ 44-304.01, 2001 Ed.).

§ 31-3408.01. Compliance with other laws.

Health maintenance organizations shall comply with the following laws:

- (1) Chapter 3 of this title;
- (2) Chapter 19 of this title;
- (3) Chapter 14 of this title;
- (4) Subchapter I of Chapter 7 of this title;
- (5) Chapter 21 of this title; and

(6) The Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title].

(Apr. 9, 1997, D.C. Law 11-235, § 9a, as added Mar. 27, 2003, D.C. Law 14-252, § 2(d), 50 DCR 225; Apr. 8, 2011, D.C. Law 18-360, § 502(a), 58 DCR 896.)

Effect of amendments. — D.C. Law 18-360 deleted “and” from the end of par. (4), substituted “; and” for a period the end of par. (5), and added par. (6).

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

Editor’s notes. — Application of Law 14-252: Section 3 of D.C. Law 14-252 provided: “This act shall not apply until the Commissioner gives written notice that all necessary rules and administrative procedures are in place to effect the provisions of this act.”

§ 31-3409. Information to enrollees.

(a) A health maintenance organization shall provide to its enrollees a list of providers, upon enrollment and re-enrollment.

(b) Every health maintenance organization shall provide to its enrollees within 30 days notice of any material change in the operation of the organization that will affect them directly.

(c) An enrollee must be notified in writing by a health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. A health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(d) A health maintenance organization shall provide to enrollees information on how services may be obtained, where additional information on access to services can be obtained, and a number where the enrollee can contact the HMO at no cost to the enrollee.

(Apr. 9, 1997, D.C. Law 11-235, § 10, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4509.

Legislative history of Law 11-235. — For

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

§ 31-3410. **Grievance procedures. [Repealed].**

Repealed.

(Apr. 9, 1997, D.C. Law 11-235, § 11, 44 DCR 818; Apr. 27, 1999, D.C. Law 12-274, § 501(a)(4), 46 DCR 1294.)

Prior Codifications. — 1981 Ed., § 35-4510.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-274. — For legislative history of D.C. Law 12-274, see His-

torical and Statutory Notes following § 31-3401.

Editor's notes. — Application of Law 12-274: Section 501(b) of D.C. Law 12-274 provided that this section shall apply upon the promulgation of regulations pursuant to § 32-574.1 § 44-304.01, 2001 Ed. .

§ 31-3411. **Investments.**

With the exception of investments made in accordance with § 31-3404(a)(1), the funds of a health maintenance organization shall be invested in accordance with NAIC Health Maintenance Organization Investment Guidelines adopted by the Commissioner.

(Apr. 9, 1997, D.C. Law 11-235, § 12, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4511.

Legislative history of Law 11-235. — For

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

§ 31-3412. **Protection against insolvency.**

(a) *Net worth requirements.* —

(1) Before issuing any certificates of authority, the Commissioner shall require that the health maintenance organization have an initial net worth of \$1,500,000 and shall thereafter maintain the minimum net worth required by paragraph (2) of this subsection.

(2) Except as provided in paragraphs (2A), (3) and (4) of this subsection, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(A) \$1,000,000;

(B) Two percent of annual dues revenues as reported on the most recent annual financial statement filed with the Commissioner on the first \$150,000,000 of dues and 1% of annual dues on the dues in excess of \$150,000,000;

(C) An amount equal to the sum of 3 months uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner; or

(D) An amount equal to the sum of:

(i) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner; and

(ii) Four percent of annual hospital expenditures paid on a managed

hospital payment basis as reported on the most recent financial statement filed with the Commissioner.

(2A) A health maintenance organization shall not be required to maintain a net worth in excess of \$4 million.

(3) A health maintenance organization meeting the exemption of § 31-3402(d)(8)(A) before April 9, 1997, and any HMO that does not meet the requirements of this section on April 9, 1997, or within 12 months of April 9, 1997, must meet and maintain the following annual minimum net worth standards.

(A) Twenty-five percent of the amount otherwise required by this section by the end of the first full calendar year following April 9, 1997;

(B) Fifty percent of the amount otherwise required by this section by the end of the second full calendar year following April 9, 1997;

(C) Seventy-five percent of the amount otherwise required by this section by the end of the third full calendar year following April 9, 1997; and

(D) One hundred percent of the amount otherwise required by this section by the end of the fourth full calendar year following April 9, 1997.

(4) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(A) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(B) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Commissioner, shall not be considered a liability and shall be recorded as equity.

(b) *Deposit requirements.* —

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the Commissioner which at all times shall have a value of not less than \$300,000.

(2)(A) A health maintenance organization that is in operation on April 9, 1997 shall make a deposit equal to \$150,000.

(B) In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on April 9, 1997 shall be equal to \$150,000, for a total of \$300,000.

(3) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(4) All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the Commissioner before being deposited or substituted.

(5) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of covered

services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The Commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of Chapter 13 of this title.

(6) The Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the District treasurer, Commissioner, or other official body of the District or jurisdiction of domicile for the protection of all enrollees, wherever located, of such health maintenance organization, cash, acceptable securities, or surety, and delivers to the Commissioner a certificate to such effect, duly authenticated by the regulatory authority in the state of domicile or by the appropriate District official holding the deposit.

(c) *Liabilities.* — Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned dues and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities may be computed in accordance with generally accepted accounting principles.

(d) *Hold harmless.* —

(1) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event a health maintenance organization fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the enrollee sums owed by a health maintenance organization.

(3) No participating provider, agent, trustee, or assignee thereof may maintain any action at law against an enrollee to collect sums owed by a health maintenance organization.

(e) *Continuation of benefits.* —

(1) The Commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

(2) In considering the plan, the Commissioner may require:

(A) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(B) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after a health maintenance

organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(C) Insolvency reserves;

(D) Acceptable letters of credit; and

(E) Any other arrangements to assure that benefits are continued as specified above.

(f) *Notice of termination.* — An agreement to provide covered services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the organization at least 60 days advance notice of termination.

(Apr. 9, 1997, D.C. Law 11-235, § 13, 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 46(c), 45 DCR 745; Mar. 27, 2003, D.C. Law 14-252, § 2(f), 50 DCR 225.)

Section references. — This section is referred to in §§ 31-3402, 31-3403, 31-3413, and 31-3419.

Prior Codifications. — 1981 Ed., § 35-4512.

Effect of amendments. — D.C. Law 14-252, in subsec. (a)(2), substituted "(2A), (3), and" for "(3) and"; and added subsec. (a)(2A).

Legislative history of Law 11-235. — For

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

§ 31-3413. Uncovered expenditures insolvency deposit.

(a) If at any time uncovered expenditures exceed 10% of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the Commissioner, or with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Commissioner. The deposit shall at all times have a fair market value in an amount of 120% of the HMO's outstanding liability for uncovered expenditures for enrollees in the District, including incurred, but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under § 31-3412 and is an admitted asset of a health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of a health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the Commissioner.

(c)(1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(A) A substitute deposit of cash or securities of equal amount and value is made;

(B) The fair market value exceeds the amount of the required deposit;
or

(C) The required deposit under subsection (a) of this section is reduced or eliminated.

(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the Commissioner.

(d) The deposit required under this section is in trust and may be used only as approved under this section. The Commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment claims of enrollees of the District for uncovered expenditures. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(e) The Commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection (d) of this section.

(f) The Commissioner may by regulation or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the Commissioner deems necessary to demonstrate compliance with this section. The Commissioner may require that the reports include liability for uncovered expenditures as well as an audit option.

(Apr. 9, 1997, D.C. Law 11-235, § 14, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4513. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.
Legislative history of Law 11-235. — For

§ 31-3414. Enrollment period; replacement coverage in the event of insolvency.

(a) *Enrollment period.* —

(1) In the event of the insolvency of a health maintenance organization, upon order of the Commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a 30-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier has been offered to groups enrolled in the insolvent health maintenance organization or if the Commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance

organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The Commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by this type of coverage in the insolvent health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

(b) *Replacement coverage.* —

(1) For the purposes of this subsection, the term "discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(3) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

(Apr. 9, 1997, D.C. Law 11-235, § 15, 44 DCR 818.)

Section references. — This section is referred to in §§ 31-3152, 31-3403, and 31-3430.

Prior Codifications. — 1981 Ed., § 35-4514.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

§ 31-3415. Filing requirements for rating information.

(a) No fees may be used until either a schedule of enrollment fees or methodology for determining enrollment fees dues has been filed with and approved by the Commissioner.

(b) Either a specific schedule of fees, or a methodology for determining fees, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the enrollment fees applicable to an enrollee shall not be individually determined based on the status of an enrollee's health. However, the fees shall not be excessive, inadequate, or unfairly discriminatory. A statement by a qualified actuary or other qualified person acceptable to the Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information. A health maintenance organization filing a schedule of enrollment fees or methodology for determining enrollment fees pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title].

(c) The Commissioner shall approve the schedule of enrollment fees dues or methodology for determining enrollment fees if the requirements of subsection (b) of this section are met. If the Commissioner disapproves the filing, the Commissioner shall notify the health maintenance organization. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing shall be held within 30 days after a request in writing by the person filing. If the Commissioner does not take action on the schedule or methodology within 30 days of the filing, it shall be deemed approved.

(Apr. 9, 1997, D.C. Law 11-235, § 16, 44 DCR 818; Apr. 8, 2011, D.C. Law 18-360, § 502(b), 58 DCR 896.)

Section references. — This section is referred to in § 31-3419.

Prior Codifications. — 1981 Ed., § 35-4515.

Effect of amendments. — D.C. Law 18-360, in subsec. (b), added the fourth sentence.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010

(D.C. Act 18-328, March 18, 2010, 57 DCR 2546).

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

§ 31-3416. Regulation of health maintenance organization producers.

(a) The Commissioner shall issue rules and regulations to provide for the licensing of health maintenance organization producers. The rules shall establish:

(1) The requirements for licensure of resident health maintenance organization producers;

(2) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(3) Any examination, prelicensing, or continuing education requirements;

(4) The requirements for registering and terminating the appointment of health maintenance organization producers;

(5) Any requirements for registering any assumed names or office locations in which a health maintenance organization producer does business;

(6) The conditions for health maintenance organization producer license renewal;

(7) The grounds for denial, refusal, suspension, or revocation of a health maintenance organization producer's license;

(8) Any required fees for the licensing activities of health maintenance organization producers; and

(9) Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

(b) The provisions of subsection (a) of this section shall not apply to the following:

(1) Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of his time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(2) Employers or their officers or employees or the trustees of any employee benefit plan to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships; provided, that such employers, officers, employees, or trustees are not in any manner compensated directly or indirectly by the health maintenance organization memberships;

(3) Banks or their officers and employees to the extent that such banks, officers, and employees collect and remit charges, charging the same against accounts of depositors on the orders of such depositors; or,

(4) Any person or the employee of any person who has contracted to provide administrative, management, or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profits of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this chapter.

(c) The Commissioner may, by rule, exempt certain classes of persons from the requirements of subsection (a) of this section if:

- (1) The functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or,
- (2) Other existing safeguards make regulation unnecessary.

(Apr. 9, 1997, D.C. Law 11-235, § 17, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4516.

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 11-235. — For

§ 31-3417. Powers of insurance corporations.

(a) An insurance company authorized to do business in the District may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other provisions of law, any 2 or more such insurance companies, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or subsidiary thereof.

(b) Notwithstanding any other provision of insurance laws, an insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of a health maintenance organization to meet its obligations.

(c) The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers.

(Apr. 9, 1997, D.C. Law 11-235, § 18, 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 46(d), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4517.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-3401.

§ 31-3418. Examinations. [Repealed].

Repealed.

(Apr. 9, 1997, D.C. Law 11-235, § 19, 44 DCR 818; Oct. 23, 1997, D.C. Law 12-32, § 12(c), 44 DCR 4819; Mar. 27, 2003, D.C. Law 14-252, 2(g), 50 DCR 225.)

Prior Codifications. — 1981 Ed., § 35-4518.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see His-

torical and Statutory Notes following § 31-3401.

Legislative history of Law 12-32. — Law 12-32, the "Healthcare Entity Conversion Act of

1997," was introduced in Council and assigned Bill No. 12-112, which was referred to the Committee on Finance and Revenue. The Bill was adopted on first and second readings on June 3, 1997, and July 1, 1997, respectively. Signed by the Mayor on July 17, 1997, it was

assigned Act No. 12-128 and transmitted to both Houses of Congress for its review. D.C. Law 12-32 became effective on October 23, 1997.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

§ 31-3419. Suspension or revocation of certificate of authority.

(a) Any certificate of authority issued under this chapter may be suspended or revoked, and any application for a certificate of authority may be denied, if the Commissioner finds that any of the conditions listed below exist:

(1) A health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner inconsistent with this chapter.

(2) A health maintenance organization issued an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of §§ 31-3407 and 31-3415.

(3) A health maintenance organization does not provide or arrange for basic health care services.

(4) The Commissioner certifies that:

(A) A health maintenance organization does not meet the requirements of § 31-3403(b); or

(B) A health maintenance organization is unable to fulfil its obligations to furnish health care services.

(5) A health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) A health maintenance organization has failed to correct, within the time prescribed by subsection (c) of this section, any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired.

(7) A health maintenance organization has failed to implement the grievance procedure required by § 31-3410 in a reasonable manner to resolve valid complaints.

(8) A health maintenance organization, or any person authorized to act on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(9) The continued operation of a health maintenance organization would be dangerous to its enrollees.

(10) The health maintenance organization has otherwise failed substantially to comply with this chapter.

(11) The health maintenance organization has filed, caused to be filed, or failed to prevent the filing of, a statement on its behalf from an independent organization attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information.

(12) The health maintenance organization has filed, caused to be filed, or failed to prevent the filing of a statement on its behalf by a corporate officer attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information.

(13) A health maintenance organization has violated a law of the District, has violated its charter, or has exceeded its corporate powers.

(b) In addition to, or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subject to an administrative penalty of up to \$1000 a day for each cause for suspension or revocation.

(c) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the Commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this chapter is less than the minimum net worth required to be maintained by § 31-3412, the Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require:

(A) Filing with the Commissioner a plan for correction of the deficiency acceptable to the Commissioner; and

(B) Correction of the deficiency within a reasonable time, not to exceed 60 days, unless an extension of time is granted by the Commissioner.

(2) Such a deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation.

(3) Except for newborn children, other newly acquired dependents of existing enrollees, or other newly eligible individuals, or as otherwise allowed by the Commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in the District, for which a premium dues is charged or collected, when a health maintenance organization writing such coverage is impaired, and the fact of the impairment is known to the health maintenance organization or to the person.

(4) The existence of an impairment, however, shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

(d) A certificate of authority shall be suspended or revoked, or an application or a certificate of authority denied, or an administrative penalty imposed only after compliance with the requirements of this section.

(1) Suspension or revocation of a certificate of authority, the denial of an application, or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, or denial or administrative penalty is based. A health maintenance organization or applicant may in writing request a hearing within 30 days from the date

of mailing of the order. If no written request is made, such order shall be final upon the expiration of the 30 days.

(2) If a health maintenance organization or applicant requests a hearing pursuant to this section, the Commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail. The notice shall include the following:

(A) A specific time for the hearing, which may not be less than 20 days nor more than 30 days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(3) If a hearing is requested, the Commissioner or his designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the Commissioner in respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Mayor.

(4) After such a hearing, or upon failure of the health maintenance organization to appear at the hearing, the Commissioner shall take whatever action he or she deems necessary based on written findings and shall mail his or her decision to the health maintenance organization or applicant. The action of the Commissioner shall be subject to review under subchapter I of Chapter 5 of Title 2.

(5) The provisions of the DCAPA shall apply to proceedings under this section.

(6) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children, other newly acquired dependents of existing enrollees, or other newly eligible individuals, and shall not engage in any advertising or solicitation whatsoever.

(7) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order or revocation, to wind up its affairs within the District, and shall conduct no further business within the District except as may be essential to the orderly conclusion of the affairs of such organization within the District. It shall engage in no further advertising or solicitation whatsoever within the District. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

(Apr. 9, 1997, D.C. Law 11-235, § 20, 44 DCR 818; Oct. 21, 2000, D.C. Law 13-190, § 4(b), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 604(b), 49 DCR 6968; Mar. 27, 2003, D.C. Law 14-252, § 2(h), 50 DCR 225; Mar. 13, 2004, D.C. Law 15-105, § 66, 51 DCR)

Section references. — This section is referred to in §§ 31-3403 and 31-3423.

Prior Codifications. — 1981 Ed., § 35-4519.

Effect of amendments. — D.C. Law 13-190 added subsec. (a)(11).

D.C. Law 14-190, in subsec. (a), added par. (12).

D.C. Law 14-252, in subsec. (a), added par. (13).

D.C. Law 15-105, in par. (13) of subsec. (a), validated a previously made technical correction.

Emergency legislation. — For temporary (90 day) amendment of section, see § 604(b) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 11-235. — For

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 13-190. — For Law 13-190, see notes following § 31-3403.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

Legislative history of Law 15-105. — For Law 15-105, see notes following § 31-2402.

§ 31-3420. Rehabilitation, liquidation, or conservation of health maintenance organizations.

(a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The Commissioner may apply for an order directing the Commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set forth in §§ 31-1310 and 31-1315, or when in the Commissioner's opinion the continued operation of a health maintenance organization would be hazardous either to the enrollees or to the people of the District. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For the purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by § 31-1315, for policyholders and beneficiaries of insured of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

(c) Any provider who is obligated by law or agreement to hold enrollees harmless from liability for services pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollee's beneficiaries as described herein, and immediately preceding the priority of distribution assigned to general creditors.

(Apr. 9, 1997, D.C. Law 11-235, § 21, 44 DCR 818; Mar. 8, 2007, D.C. Law 16-232, § 204(b), 54 DCR 368.)

Prior Codifications. — 1981 Ed., § 35-4520.

Effect of amendments. — D.C. Law 16-232, in subsec. (c), substituted "law" for "statute" and inserted "assigned to general creditors".

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

§ 31-3421. Summary orders and supervision.

(a) Whenever the Commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the Commissioner may, after notice and hearing, order the health maintenance organization to take such action reasonably necessary to rectify the condition or violation, including, but not limited to, 1 or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the Commissioner;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take such other steps as the Commissioner may deem appropriate under the circumstances.

(b) For the purposes of this section, a violation by a health maintenance organization of any law of the District to which the health maintenance organization is subject shall be deemed a violation of this chapter.

(c) The Commissioner is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purpose expressed in subsection (a) of this section.

(d) The remedies and measures available to the Commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the Commissioner under the provisions of Chapter 13 of this title.

(Apr. 9, 1997, D.C. Law 11-235, § 22, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4521. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 11-235. — For

§ 31-3422. Regulations.

The Commissioner, within 120 days of April 9, 1997, shall issue rules and regulations necessary to implement the provisions of this chapter. To facilitate the timely issuance of rules and regulations, the Commissioner may contract out for the drafting of rules and regulations pursuant to emergency procurement provisions set forth in § 2-303.12.

(Apr. 9, 1997, D.C. Law 11-235, § 23, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4522. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 11-235. — For

§ 31-3423. Penalties and enforcement.

(a) The Commissioner, after giving reasonable written notice of intent and providing a reasonable time within which the health maintenance organization may respond, in lieu of suspension or revocation of a certificate of authority under § 31-3419, may levy an administrative penalty in an amount not to exceed \$50,000 for any violation when, in the Commissioner's judgment, the Commissioner finds that the public interest would be best served by the continued operation of the company. The Commissioner may increase this penalty by the amount which the Commissioner determines to be the damages suffered by enrollees or other members of the public. The amount of any penalty shall be paid by the health maintenance organization through the Office of the Commissioner to the District of Columbia Treasurer. Civil penalties may be imposed as alternative sanctions for any infraction of the provisions of District law or any rules or regulations issued which pertain to health maintenance organizations.

(b)(1) If the Commissioner shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the Commissioner may give notice to a health maintenance organization and to its representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation; and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section are satisfied.

(c)(1) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

(2) Within 30 days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. Such hearings shall be conducted pursuant to the DCAPA, and judicial review shall be available as provided by the DCAPA.

(d) In the case of any violation of the provisions of this chapter, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (c) of this section, the Commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Superior Court of the District of Columbia.

(e) Notwithstanding any other provisions of this chapter, if a health maintenance organization fails to comply with the net worth requirement of this

chapter, the Commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

(Apr. 9, 1997, D.C. Law 11-235, § 25, 44 DCR 818; Mar. 27, 2003, D.C. Law 14-252, § 2(i), 50 DCR 225.)

Prior Codifications. — 1981 Ed., § 35-4523.

Effect of amendments. — D.C. Law 14-252 rewrote subsec. (a) which had read as follows: “(a) The Commissioner may, in lieu of suspension or revocation of a certificate of authority under § 31-3419, levy an administrative penalty in an amount not less than \$10,000 nor more than \$50,000, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the

defect in its operations which gave rise to the penalty citation. The Commissioner may augment this penalty by an amount equal to the sum that the Commissioner calculates to be the damages suffered by enrollees or other members of the public.”

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

§ 31-3424. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this chapter, provisions of insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws of the District except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provisions set forth by the Board of Medicine relating to the practice of medicine.

(Apr. 9, 1997, D.C. Law 11-235, § 26, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4524.

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 11-235. — For

§ 31-3425. Filings and reports as public documents.

All applications, filings, and reports required under this chapter shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial, and financial information, other than any annual financial statement that may be required under § 31-3408 [repealed].

(Apr. 9, 1997, D.C. Law 11-235, § 27, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4525. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-

Legislative history of Law 11-235. — For 3401.

§ 31-3426. Confidentiality of medical information and limitation of liability.

(a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter:

(1) When needed for the conduct of the health maintenance organization's business;

(2) Upon the express consent of the enrollee or applicant;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent.

(b) A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

(c) A person who, in good faith and without malice or negligence, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee, or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the health maintenance organization which established such committee or the officers, directors, employees, or agents of such health maintenance organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(d)(1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate District of Columbia licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of the health maintenance organization or its staff engaged in assisting such committee, or any person assisting or furnishing information to such committee, may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its action and proceedings which are used pursuant to this subsection by a state licensing or certifying agency or in appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

(e) To fulfill its obligations under § 31-3406, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

(Apr. 9, 1997, D.C. Law 11-235, § 28, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4526. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

§ 31-3427. Acquisition of control of or merger of a health maintenance organization.

(a) No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization, or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly (or by conversion or by exercise of any right to acquire), be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the Commissioner and has sent to the health maintenance organization the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to herein is to be effected (hereinafter called “acquiring party”); and

(A) If such person is an individual, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations during the past 10 years; or

(B) If such person is not an individual, a report of the nature of its business operations during the past 5 years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person’s subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (A) of this paragraph;

(2) The source, nature, and amount of the consideration used, or to be used, in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing such considerations; provided, that where a source of such consideration is a loan made in the lender’s ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate such health maintenance organizations, to sell its assets, or merge or consolidate it with any person; or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to herein which each acquiring party proposes to acquire and the terms of the offer, request, invitation, agreement, or acquisition referred to herein, and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to herein which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to herein in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such descriptions shall identify the persons with whom such contracts, arrangements, or understandings have been entered into;

(8) A description of the purchase of any security referred to herein during the 12 calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor;

(9) A description of any recommendations to purchase any security referred to herein made during the 12 calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party;

(10) Copies of all tender offers for, requests or invitations for tenders of exchange offers for, and agreements to acquire or exchange any securities referred to herein, and (if distributed) of additional soliciting material relating thereto;

(11) The terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to herein for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto; and

(12) Such additional information as the Commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of members and security holders of the health maintenance organization or in the public interest.

(b) If the person required to file the statement referred to in this section is a partnership, limited partnership, syndicate, or other group, the Commis-

sioner may require that the information called for by subsection (a)(1) through (8) of this section shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement referred to herein is a corporation, the Commissioner may require that the information called for by subsection (a)(1) through (8) of this section shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of such corporation. If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such health maintenance organization pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such insurer within 2 business days after the person learns of such change. Such insurer shall send such amendment to its shareholders.

(Apr. 9, 1997, D.C. Law 11-235, § 29, 44 DCR 818; Mar. 24, 1998, D.C. Law 12-81, § 46(e), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-4527.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-3401.

§ 31-3428. Coordination of benefits. [Repealed].

Repealed.

(Apr. 9, 1997, D.C. Law 11-235, § 30, 44 DCR 818; Mar. 27, 2003, D.C. Law 14-252, § 2(j), 50 DCR 225.)

Prior Codifications. — 1981 Ed., § 35-4528.

Legislative history of Law 11-235. — For legislative history of D.C. Law 11-235, see His-

torical and Statutory Notes following § 31-3401.

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

§ 31-3429. Point of service plan.

(a) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through a health maintenance organization, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another carrier to offer, a point-of-service option to the employer, association, or other private group arrangement in conjunction with the health maintenance organization as an additional benefit for an employee or individual, at the employee's or individual's option to accept or reject.

(b) An employer, association, or other private group arrangement may

require an employee or individual that accepts the additional coverage under a point-of-service option under subsection (a) of this section to pay a premium over the amount of the premium for the coverage offered by the health maintenance organization.

(c) A health maintenance organization may impose different cost sharing provisions for the point-of-service option based on whether the service is provided through the provider panel of the health maintenance organization or outside the providers panel of the health maintenance organization.

(d) The requirements of this section shall not apply to any subscriber contract current and in force on April 9, 1997 for the duration of that contract, but these requirements shall apply to any renewal or new subscriber contract issued subsequent to April 9, 1997.

(e) The requirements of this section shall not apply to any subscriber contract issued in the individual market to a person who is not part of a contracted group of subscribers.

(Apr. 9, 1997, D.C. Law 11-235, § 31, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4529. legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-

Legislative history of Law 11-235. — For 3401.

§ 31-3430. Insolvency protection; assessment.

(a) When a health maintenance organization in the District is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on health maintenance organizations doing business in the District to pay claims for uncovered expenditures for enrollees who are residents of the District and to provide continuation of coverage for enrollees not covered under § 31-3414. The Commissioner may not assess in any one calendar year more than 2% of the aggregate premium written by each health maintenance organization in the District the prior calendar year.

(b) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent health maintenance organization who are residents of the District, provide for continuation of coverage for enrollees who are residents of the District and are not covered under § 31-3414, and administrative costs. The Commissioner may by regulation prescribe the time, manner, and form for filing claims under this section, or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

(c) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(1) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by a payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon such person. The Commissioner is

subrogated to these rights against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(2) The assignment or subrogation rights of the Commissioner and allowed claim under this subsection have the same priority against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(d) When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the Commissioner will distribute on a pro rata basis any amounts received under subsection (a) of this section which are not de minimus to the health maintenance organizations which have been assessed under this section.

(e) The aggregate coverage of uncovered expenditures under this section shall not exceed \$300,000 with respect to any one individual. Continuation of coverage shall not continue for more than the lesser of 1 year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The Commissioner may provide continuation of coverage on any reasonable basis, including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the Commissioner.

(f) The Commissioner may waive an assessment of any health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within 30 days after notice is subject to a civil forfeiture of not more than \$1,000 per day or suspension or revocation of its certificate of authority, or both. Any action taken by the Commissioner in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with the DCAPA.

(Apr. 9, 1997, D.C. Law 11-235, § 32, 44 DCR 818.)

Prior Codifications. — 1981 Ed., § 35-4530.

legislative history of D.C. Law 11-235, see Historical and Statutory Notes following § 31-3401.

Legislative history of Law 11-235. — For

§ 31-3431. Principal office, books, records, and files of the health maintenance organization to be in the District.

(a) Any health maintenance organization domiciled in the District or hereafter formed or organized in the District to engage in the health care business as a health maintenance organization shall maintain its principal office within the District, shall keep its books, records, and files in the District, and shall not remove from the District its principal office or its books, records, or files without first obtaining the written permission of the Commissioner; provided, that this section shall not apply to the books, records, and files of any branch office of a health maintenance organization, which books, records, and files relate solely to the business transacted by the branch office agency.

(b) A health maintenance organization domiciled in the District which

violates this section shall immediately forfeit its certificate of authority to do business in the District.

(c) An officer, agent, or employee of a health maintenance organization which violates this section shall be guilty of a misdemeanor and, upon conviction, shall pay a fine of not less than \$100 for each offense.

(Apr. 9, 1997, D.C. Law 11-235, § 32a, as added Mar. 27, 2003, D.C. Law 14-252, § 2(k), 50 DCR 225.)

Legislative history of Law 14-252. — For Law 14-252, see notes following § 31-3402.

Editor's notes. — Application of Law 14-252: Section 3 of D.C. Law 14-252 provided:

"This act shall not apply until the Commissioner gives written notice that all necessary rules and administrative procedures are in place to effect the provisions of this act."

CHAPTER 35. HOSPITAL AND MEDICAL SERVICES CORPORATIONS REGULATION.

Sec.	Sec.
31-3501. Definitions.	31-3513. Reports.
31-3502. Exclusivity of provisions.	31-3514. Open enrollment.
31-3503. Applicability of other provisions.	31-3514.01. Tax and related payments.
31-3504. Application for certificate of authority.	31-3514.02. Establishment of Healthy DC and Health Care Expansion Fund.
31-3505. Requirements for issuance of certificate of authority.	31-3515. Conversion to a for-profit entity.
31-3505.01. Community health reinvestment.	31-3516. Conversion to a mutual company.
31-3506. Surplus requirements.	31-3517. Management contracts and service agreements.
31-3506.01. Compliance and implementation of community health reinvestment obligations.	31-3518. Directors and trustees.
31-3507. Filing of provider contracts.	31-3519. Reports to directors and trustees.
31-3508. Filing of subscriber contract forms and rates.	31-3520. Oversight role and fiduciary obligation of directors, officers, and employees.
31-3509. Reserves.	31-3521. Sanctions for violations.
31-3510. Investments.	31-3522. Appeals.
31-3511. Surplus notes.	31-3523. General transition provisions.
31-3512. Group subscriber contract standard provisions.	31-3523.01. Regulatory authority.
	31-3524. Rules and regulations.

§ 31-3501. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(1A) "Community health reinvestment" means expenditures that promote and safeguard the public health or that benefit current or future subscribers, including premium rate reductions.

(1B) "Contractholder" means a person entering into a subscriber contract with a corporation.

(2) "Corporation" means a nonstock, nonprofit corporation which is subject to regulation and licensing under this chapter and which offers subscriber contracts as part of a hospital service plan, a medical service plan, or both.

(3) "Domestic corporation" means a corporation organized under the laws of the District, or formed or organized under an act of Congress.

(3A) "Healthy DC and Health Care Expansion Fund" means the Healthy DC and Health Care Expansion Fund established by § 31-3514.02.

(4) "Hospital service plan" means a plan for providing hospital and related services by hospitals and others which entitles a subscriber to certain hospital and related services, or to benefits and indemnification for such services.

(5) "Mayor" means the Mayor of the District of Columbia or the Mayor's designated agent.

(6) "Medical service plan" means a plan for providing medical services and related services by physicians and others which entitles a subscriber to certain medical and related services, or to benefits and indemnification for such services.

(7) "Plan" means a hospital service plan, a medical service plan, or a combination of the two.

(7A) "Public-private partnership" means a mutually acceptable written agreement between the Mayor and a hospital and medical services corporation that is certified by the Commissioner upon the execution and delivery of the agreement by the parties and which agreement:

(A) Shall include the following provisions:

(i) A \$5 million annual payment to the Healthy DC Fund (or appropriate successor fund) by the hospital and medical services corporation to be used for subsidies that expand health insurance coverage for low-income District residents;

(ii) A targeted city-wide health care initiative aimed at improving nutrition and increasing physical fitness among the District's senior citizens, or another comparable health promotion program;

(iii) A term not to exceed 5 years, subject to extension upon the mutual written agreement of the parties;

(iv)(I)(aa) The maintenance and support of the existing District open enrollment program as it operated prior to the enactment of the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369; 56 DCR 1346) ("open enrollment program"), which program has an estimated average premium of \$357 per member per month, and the enhancement of the open enrollment program by offering a new health maintenance organization product that includes comprehensive benefits with an average initial premium currently estimated at about \$300 per member per month, which average may vary based upon age and family status, and subject to other reasonable adjustments, but with no adjustments for gender or pre-existing conditions.

(bb) The annual premium rate of the existing open enrollment program shall not exceed 125% of the comparable medically underwritten product and shall be determined once every 12 months. The benefit package shall include, at a minimum, primary care services, specialist services, temporomandibular joint problems chiropractic services, mental health and addiction treatment, organ transplantation, treatment for morbid obesity, open heart surgery, and pharmaceutical benefits.

(cc) The medical loss ratio to be utilized in rate filings and determinations shall not exceed 150%;

(II) Under the open enrollment program pursuant to sub-subparagraph (I) of this sub-subparagraph:

(aa) Current members shall be permitted to maintain the option to continue their current open enrollment program coverage or opt for the new health maintenance organization product;

(bb) New open enrollment members shall only be offered the new health maintenance organization product; and

(cc) Total enrollment under subparagraph (A)(iv)(I) of this paragraph shall be capped at 2,500;

(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents, which shall be subject to periodic confirmation; and

(vi)(I) A corporation shall prominently advertise the availability of the new open enrollment health maintenance organization product continu-

ously on the Internet and at least quarterly in a newspaper of general circulation throughout the District.

(II) The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet;

(B) May include the following provisions:

(i) Authority for the Commissioner to grant a hospital and medical services corporation reasonable relief from the requirements of the agreement, such as if federal or state health care reforms make the requirements unnecessary or redundant or if the corporation does not meet a financial performance or similar test as specified in the agreement; provided, that any relief granted shall not affect the certification of the agreement by the Commissioner or the status of the agreement as a public-private partnership for all purposes under this chapter; and

(ii) Reasonable expiration and termination provisions; and

(C) Shall be effective upon the certification of the Commissioner.

(7B) "RS Fund" means the rate stabilization fund established by § 31-3514(j).

(8) "Subscriber" means any person entitled to benefits under the terms and conditions of a subscriber contract.

(9) "Subscriber contract" means a written group or individual contract which is issued to a contractholder by a corporation which provides for subscriber participation in a hospital service plan, a medical service plan, or a combination of the two.

(10) "Subsidiary" means an affiliate controlled by a corporation directly or indirectly through 1 or more intermediaries.

(11) "Surplus" means the amount by which all admitted assets of the corporation exceed its liabilities, inclusive of the reserves required pursuant to § 31-3509.

(Apr. 9, 1997, D.C. Law 11-245, § 2, 44 DCR 1158; Mar. 2, 2007, D.C. Law 16-192, § 5012(a), 53 DCR 6899; Mar. 25, 2009, D.C. Law 17-369, § 2(a), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18-104, § 2(a), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18-223, § 5023(a), 57 DCR 6242.)

Prior Codifications. — 1981 Ed., § 35-4701.

Effect of amendments. — D.C. Law 16-192 added pars. (3A) and (7A).

D.C. Law 17-369 redesignated former par. (1) as par. (1B); and added pars. (1) and (1A).

D.C. Law 18-104 redesignated former par. (7A) as par. (7B); and added par. (7A).

D.C. Law 18-223, in par. (3A), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund" both times it appears.

Temporary Amendment of Section. — Section 2(a) of D.C. Law 18-134 designated par. (7A) as par. (7B); and added par. (7A) to read as follows:

"(7A) Public-private partnership' means a mutually acceptable written agreement between the Mayor and a hospital and medical services corporation that is certified by the Commissioner upon the execution and delivery of the agreement by the parties and which agreement:

"(A) Shall include the following provisions:

"(i) A \$5 million annual payment to the Healthy DC Fund (or appropriate successor fund) by the hospital and medical services corporation to be used for subsidies that expand health insurance coverage for low-income District residents;

"(ii) A targeted city-wide health care initiative aimed at improving nutrition and increas-

ing physical fitness among the District's senior citizens, or another comparable health promotion program;

"(iii) A term not to exceed 5 years, subject to extension upon the mutual written agreement of the parties;

"(iv)(I)(aa) The maintenance and support of the existing District open enrollment program as it operated prior to the enactment of the Medical Insurance Empowerment Amendment Act of 2008, effective March 25, 2009 (D.C. Law 17-369; 56 DCR 1346) ('open enrollment program'), which program has an estimated average premium of \$357 per member per month, and the enhancement of the open enrollment program by offering a new health maintenance organization product that includes comprehensive benefits with an average initial premium currently estimated at about \$300 per member per month, which average may vary based upon age and family status, and subject to other reasonable adjustments, but with no adjustments for gender or pre-existing conditions.

"(bb) The annual premium rate of the existing open enrollment program shall not exceed 125% of the comparable medically underwritten product and shall be determined once every 12 months. The benefit package of the health maintenance organization product shall include, at a minimum, primary care services, specialist services, temporomandibular joint problems chiropractic services, mental health and addiction treatment, organ transplantation, treatment for morbid obesity, open heart surgery, and pharmaceutical benefits.

"(cc) The medical loss ratio of the health maintenance organization product to be utilized in rate filings and determinations shall not exceed 150%;

"(II) Under the open enrollment program pursuant to sub-subparagraph (I) of this sub-subparagraph:

"(aa) Current members shall be permitted to maintain the option to continue their current open enrollment program coverage or opt for the new health maintenance organization product;

"(bb) New open enrollment members shall only be offered the new health maintenance organization product; and

"(cc) Total enrollment under subparagraph A)(iv)(I) of this paragraph shall be capped at 2,500;

"(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents, which shall be subject to periodic confirmation; and

"(vi)(I) A corporation shall prominently advertise the availability of the new open enrollment health maintenance organization product continuously on the Internet and at least quar-

terly in a newspaper of general circulation throughout the District.

"(II) The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet;

"(B) May include the following provisions:

"(i) Authority for the Commissioner to grant a hospital and medical services corporation reasonable relief from the requirements of the agreement, such as if federal or state health care reforms make the requirements unnecessary or redundant or if the corporation does not meet a financial performance or similar test as specified in the agreement; provided, that any relief granted shall not affect the certification of the agreement by the Commissioner or the status of the agreement as a public-private partnership for all purposes under this act; and

"(ii) Reasonable expiration and termination provisions; and

"(C) Shall be effective upon the certification of the Commissioner."

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Section 3(a) of D.C. Law 18-205, in par. (3A), substituted "Healthy DC and Health Care Expansion Fund" for "Healthy DC Fund" both times it appears.

Section 7(b) of D.C. Law 18-205 provided that the act shall expire after 225 days of its having taken effect.

Section 201(a) of D.C. Law 18-271 amended subsec. (7A)(A)(v) to read as follows:

"(v) Participation in the open enrollment program (including the health maintenance organization product) may be limited to District residents who are ineligible for the DC High Risk Pool Program, as defined in the DC High Risk Pool Program Establishment Temporary Act of 2010, passed on 2nd reading on September 21, 2010 (Enrolled version of Bill 18-939). Participant eligibility shall be subject to periodic confirmation; and"

Section 302(b) of D.C. Law 18-271 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 5012(a) of Fiscal Year 2007 Budget Support Emergency Act of 2006 (D.C. Act 16-477, August 8, 2006, 53 DCR 7068).

For temporary (90 day) amendment of section, see § 5012(a) of Fiscal Year 2007 Budget Support Congressional Review Emergency Act of 2006 (D.C. Act 16-499, October 23, 2006, 53 DCR 8845).

For temporary (90 day) amendment of section, see § 5012(a) of Fiscal Year 2007 Budget Support Congressional Review Emergency Act of 2007 (D.C. Act 17-1, January 16, 2007, 54 DCR 1165).

For temporary (90 day) amendment of section, see § 2(a) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 3(a) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18-390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 201(a) of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18-522, August 3, 2010, 57 DCR 8001).

For temporary (90 day) amendment of section, see § 5023(a) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 11-245. — Law 11-245, the “Hospital and Medical Services Corporation Regulatory Act of 1996,” was introduced in Council and assigned Bill No. 11-780, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on Novem-

ber 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-505 and transmitted to both Houses of Congress for its review. D.C. Law 11-245 became law on April 9, 1997.

Legislative history of Law 16-192. — For Law 16-192, see notes following § 31-205.

Legislative history of Law 17-369. — Law 17-369, the “Medical Insurance Empowerment Amendment Act of 2008,” was introduced in Council and assigned Bill No. 17-934 which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on December 2, 2008, and December 16, 2008, respectively. Approved without signature of the Mayor on January 23, 2009, it was assigned Act No. 17-704 and transmitted to both Houses of Congress for its review. D.C. Law 17-369 became effective on March 25,

Short title. — Short title: Section 5011 of D.C. Law 16-192 provided that subtitle B of title V of the act may be cited as the “Hospital and Medical Services Corporation Regulatory Amendment Act of 2006”.

§ 31-3502. Exclusivity of provisions.

(a) Except as provided in subsection (b) of this section, a corporation organized under the laws of the District of Columbia, or any state, or chartered by act of the Congress of the United States and issuing subscriber contracts in the District of Columbia shall be governed by this chapter and shall be exempt from all other provisions of District of Columbia law governing insurance, except as specifically referred to herein. No insurance law hereafter enacted by the District of Columbia shall be deemed to apply to such a corporation unless it is specifically referred to therein or unless such law represents an amendment or replacement of an insurance law made applicable to such corporations pursuant to § 31-3503. Any regulations promulgated by the Mayor to implement the provisions of any law made applicable to such a corporation by this chapter shall also apply to such a corporation.

(b)(1) A conversion or management or service contract with a for-profit entity shall not be approved by the Corporation Counsel unless charitable assets, if any, have been adequately protected. In determining whether charitable assets have been adequately protected, the Corporation Counsel shall apply the standard enumerated in § 44-603(c).

(2) The Commissioner of the Department of Insurance, Securities, and Banking, in consultation with the Corporation Counsel, shall assess the for-profit entity the necessary or appropriate costs related to, and shall expend such amounts for, the review of the conversion or management or service contract with a for-profit entity. Such costs may include the costs of expert review, educating the public, or obtaining public comments. For purposes of costs assessed and expended under this paragraph, the provisions of Unit A of Chapter 3 of Title 2 shall not apply.

(3) The provisions of §§ 44-605 and 44-607 shall apply to any conversions or management or service contracts with a for-profit entity.

(Apr. 9, 1997, D.C. Law 11-245, § 3, 44 DCR 1158; Oct. 23, 1997, D.C. Law 12-32, § 12(b), 44 DCR 4819; Mar. 25, 2003, D.C. Law 14-236, § 3, 49 DCR 10483; June 11, 2004, D.C. Law 15-166, § 4(u)(1), 51 DCR 2817.)

Cross references. — Healthcare entity conversion, see § 44-601 et seq.

Prior Codifications. — 1981 Ed., § 35-4702.

Effect of amendments. — D.C. Law 14-236, in subsec. (b)(2), added the last sentence.

D.C. Law 15-166, in par. (2) of subsec. (b), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3 of Department of Insurance and Securities Regulation Procurement Temporary Act of 2002 (D.C. Law 14-159, June 25, 2002, law notification 49 DCR 6495).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3 of Department of Insurance and Securities Regulation Procurement Emergency Act of 2002 (D.C. Act 14-314, March 26, 2002, 49 DCR 3451).

For temporary (90 day) amendment of section, see § 3 of Department of Insurance and Securities Regulation Procurement Congressional Review Emergency Act of 2003 (D.C. Act 15-9, January 27, 2003, 50 DCR 1478).

For temporary (90 day) amendment of section, see § 4(u)(1) of Consolidation of Financial

Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 12-32. — Law 12-32, the “Healthcare Entity Conversion Act of 1997,” was introduced in Council and assigned Bill No. 12-112, which was referred to the Committee on Finance and Revenue. The Bill was adopted on first and second readings on June 3, 1997, and July 1, 1997, respectively. Signed by the Mayor on July 17, 1997, it was assigned Act No. 12-128 and transmitted to both Houses of Congress for its review. D.C. Law 12-32 became effective on October 23, 1997.

Legislative history of Law 14-236. — For Law 14-236, see notes following § 31-1406.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 11-245, the Hospital and Medical Services Corporation Regulatory Act of 1996, see Mayor’s Order 97-133, July 30, 1997 (44 DCR 4547).

§ 31-3503. Applicability of other provisions.

(a) A corporation governed by this chapter shall also be subject to the following other provisions of District of Columbia insurance law, including any amendments or replacements thereof hereafter enacted:

(1) Sections 31-201 [repealed], 31-202, and 31-206, referring to general provisions of insurance regulation;

(2) Section 31-207, referring to general provisions of insurance regulation;

(3) Sections 31-5203 and 31-5204, referring to delivery (with each policy issued) of a copy of the insured’s application, and to the principal office, books, and records of insurance companies;

(4) Chapter 16 of this title, referring to prohibition against discrimination in the provision of insurance on the basis of an AIDS test;

(5) Chapter 42 of this title, referring to the applicability of, and definitions in, the Life Insurance Act;

(6) Sections 31-4301, 31-4302, 31-4303, 31-4305, 31-4308 [repealed], 31-4309 [repealed], 31-4310(b), 31-4311 [repealed], 31-4312 through 31-4317, 31-4322 [repealed], 31-4324 through 31-4328 [repealed], and 31-4329 through 31-4332, governing, in part, fees chargeable to, certificates of authority for,

publication of false statements by, and licensing of agents acting for life insurance companies;

(7) Sections 31-4713 through 31-4715 [repealed], 31-4718 [repealed], and 31-4724 through 31-4730, referring, in part, to the prohibitions against discrimination, securities, operations, and policy provisions restricting access to optometrists and psychologists by life insurance companies;

(8) Sections 31-4401 through 31-4404, 31-4406, 31-4407, 31-4409, 31-4427, 31-4429, 31-4430, 31-4435 [repealed], 31-4439, 31-4440, and 31-4443 through 31-4452, referring, in part, to articles of incorporation, election of officers, permissible investments, bookkeeping, and consolidation/merger of domestic life insurance companies;

(9) Chapter 46 of this title, governing penalties for violations and severability with respect to the provisions cited in paragraphs 5 through 8 of this subsection;

(10) Chapter 38 of this title, requiring that certain individual and group health insurance policies cover a newborn child from the moment of birth;

(11) Chapter 54 of this title, creating the District of Columbia Life and Health Insurance Guarantee Association and authorizing it to assume, guarantee, and reinsure any policy issued by a member insurer which becomes potentially unable to fulfill its contractual obligations;

(12) Chapter 31 of this title, requiring certain group and individual health insurance policies to provide coverage for the medical and psychological treatment of alcohol abuse, drug abuse, and mental illness;

(13) Chapter 29 of this title, requiring a group or individual health insurance policy issued more than 120 days after March 7, 1991, to cover certain preventive cancer screens for women;

(14) Chapter 37 of this title, authorizing the Mayor to issue regulations establishing specific standards for Medicare supplement insurance policies;

(15) Chapter 12 of this title, establishing the Insurance Regulatory Trust Fund and requiring each insurer doing business in the District to deposit in the Fund a percentage amount to be used to defray expenses of the Insurance Administration;

(16) Chapter 13 of this title, authorizing and regulating delinquency proceedings by the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] in the Superior Court of the District of Columbia against certain insurers;

(17) Chapter 15 of this title, establishing licensing and other requirements for managing general agents of certain insurers;

(18) Chapter 18 of this title, establishing licensing and other requirements for the assumed reinsurance business;

(19) Chapter 3 of this title, requiring insurers to file with the Mayor an accountant-prepared annual audit and other reports;

(20) Chapter 5 of this title, governing the circumstances under which a domestic insurer may obtain a credit for reinsurance ceded to another insurer;

(21) Chapter 19 of this title, governing an insurer's filing with the Mayor and the National Association of Insurance Commissioners ("NAIC") of an annual financial statement;

(22) Chapter 21 of this title, establishing standards for determining whether the continued operation of any insurer transacting business in the District might be hazardous to creditors, the general public, or policyholders, and authorizing the Mayor to order certain corrective actions after making such a determination;

(23) Chapter 14 of this title, governing examinations by the Mayor or any person subject to the District's insurance laws;

(24) Chapter 7 of this title, governing certain acquisition, investment, security issuance, and other activities in the insurance industry, requiring the registration of insurers that are part of an insurance holding company system, regulating transactions within such a system, regulating the management of domestic insurers in such a system, and authorizing the Mayor to conduct examinations of insurers that are part of such a system;

(25) Chapter 49 of this title, requiring the submission to the Mayor of an annual opinion by a qualified actuary;

(26) Chapter 26 of Title 47, requiring an annual license or certificate of authority from the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] for each insurer doing business in the District, requiring the filing of an annual statement by each such insurer, and imposing a tax on each such insurer's at-risk business in the District;

(27) Chapter 20 of this title, requiring insurers to file with the Mayor annual risk-based capital reports; and

(28) The Reasonable Health Insurance Ratemaking Reform Act of 2010, [Chapters 30A, 31C, and 33A this title] [D.C. Law 18-360].

(b) Reference in the provisions cited in subsection (a) of this section to "insurers," "companies," or similar terms shall be deemed to include reference to a corporation governed by this chapter.

(Apr. 9, 1997, D.C. Law 11-245, § 4, 44 DCR 1158; Mar. 25, 2009, D.C. Law 17-369, § 2(b), 56 DCR 1346; Apr. 8, 2011, D.C. Law 18-360, § 503(a), 58 DCR 896.)

Prior Codifications. — 1981 Ed., § 35-4703.

Effect of amendments. — D.C. Law 17-369, in subsec. (a), deleted "; and" from the end of par. (25); substituted "; and" for a period at the end of par. (26), and added par. (27).

D.C. Law 18-360 deleted "and" from the end of par. (26); substituted "; and" for a period the end of par. (27); and added par. (28).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

§ 31-3504. Application for certificate of authority.

(a) No corporation subject to the provisions of this chapter, whether organized pursuant to the laws of the District of Columbia, or of any state, or by act of the Congress of the United States, shall issue subscriber contracts until the Mayor has authorized it to do so by issuance of a certificate of authority.

(b) Application for such certificate of authority shall be made on forms to be

supplied by the Mayor containing such information as the Mayor shall deem necessary. Each application for such certificate of authority, including each application for renewal, shall contain payment of a fee of \$200 to the District of Columbia, which shall be collected by the Commissioner of the Department of Insurance, Securities, and Banking and shall be accompanied by copies of the following documents, duly certified by an executive officer of such corporation:

- (1) Articles of incorporation, with all amendments thereto;
 - (2) Bylaws, with all amendments thereto;
 - (3) Each contract form executed or proposed to be executed by and between the corporation and any hospital, physician, or other medical service provider embodying the terms under which hospital and medical service is to be furnished to subscribers;
 - (4) Each form of subscriber contract issued or proposed to be issued, together with a table of rates charged, or proposed to be charged, including actuarial justifications, to subscribers;
 - (5) A financial statement of the corporation, which shall include the amount of each contribution paid or agreed to be paid to the corporation for working capital, the name or names of each contributor, and the terms of each contribution;
 - (6) A risk-based capital report prepared in the manner prescribed by any risk-based capital ("RBC") regulations for hospital and medical services corporations promulgated by the Mayor;
 - (7) A list of the names and addresses and biographical information for the members of the board of directors, or board of trustees, and for the officers of the corporation;
 - (8) A statement of the geographical area in which the corporation proposes to operate; and
 - (9) Any other information or documents the Mayor deems necessary to assure compliance with this chapter.
- (c) In addition, if the applicant is a foreign corporation:
- (1) It shall provide the Mayor with an instrument authorizing service of process on the Mayor in accordance with § 31-4323;
 - (2) It shall satisfy the Mayor that the corporation is duly organized under the laws of the state under whose laws it professes to be organized, and is authorized to do the business it is transacting or proposes to transact; and
 - (3) It shall satisfy the Mayor that its funds are invested in accordance with the laws of its domicile and in securities or property which afford a degree of financial security substantially equal to that required for a corporation organized under the laws of the District of Columbia, and that it has a surplus at least equal to that required to be maintained by corporations authorized to do business pursuant to the provisions of this chapter.

(Apr. 9, 1997, D.C. Law 11-245, § 5, 44 DCR 1158; Mar. 24, 1998, D.C. Law 12-81, § 47, 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(u)(2), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4704.

Effect of amendments. — D.C. Law 15-166, in subsec. (b), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(u)(2) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

References in text. — Section 31-4323, referred to in subsection (c), was repealed March 21, 1995, by § 12 of D.C. Law 10-233.

§ 31-3505. Requirements for issuance of certificate of authority.

The Mayor shall issue a certificate of authority to each applicant upon the payment of the \$200 fee provided for in § 31-3504(b), and upon being satisfied that:

(a) The applicant has been organized bona fide for the purpose of establishing, maintaining, and operating a hospital service plan, a medical service plan, or combination of the two;

(b) Each contract executed, or proposed to be executed, by the applicant and any hospital, physician, or other medical provider for the furnishing of hospital or medical services to subscribers obligates, or will when executed obligate, each hospital, physician, or other similar service provider which is a party thereto to render the service to which each subscriber may be entitled under the terms and conditions of the various subscriber contracts issued, or proposed to be issued, by the applicant;

(c) Each subscriber contract issued, or proposed to be issued, in the District of Columbia is in a form approved by the Mayor, and that the rate charged, or proposed to be charged, for each form of such contract is approved by the Mayor as not being excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered; provided, that rates for experience rated groups need not, in accordance with § 31-3508(c), be filed with the Mayor;

(d) The applicant has a surplus of an amount equal to or greater than that required under § 31-3506, or the amount determined to be necessary pursuant to application of any risk-based capital regulations for hospital and medical services corporations promulgated by the Mayor; and

(e) The applicant has:

(1) Made provision for compliance with the open enrollment requirements of § 31-3514, including the providing of other public services in the District; or

(2) Has entered into a public-private partnership.

(Apr. 9, 1997, D.C. Law 11-245, § 6, 44 DCR 1158; Feb. 4, 2010, D.C. Law 18-104, § 2(b), 56 DCR 9182.)

Prior Codifications. — 1981 Ed., § 35-4705.

Effect of amendments. — D.C. Law 18-104 rewrote subsec. (e), which had read as follows: “(e) The applicant has made provision for compliance with the open enrollment requirements of § 31-3514, including the providing of other public services in the District of Columbia as required in § 31-3514.”

Temporary Amendment of Section. — Section 2(b) of D.C. Law 18-134 amended subsec. (e) to read as follows:

“(e) The applicant has:

“(1) Made provision for compliance with the open enrollment requirements of section 15, including the providing of other public services in the District; or

“(2) Has entered into a public-private partnership.”

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2(b) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 18-104. — For Law 18-104, see notes following § 31-205.

§ 31-3505.01. Community health reinvestment.

A corporation shall engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency.

(Apr. 9, 1997, D.C. Law 11-245, § 6a, as added Mar. 25, 2009, D.C. Law 17-369, § 2(c), 56 DCR 1346.)

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

§ 31-3506. Surplus requirements.

(a) At the time of issuance of a certificate of authority under this chapter and at all times thereafter until risk-based capital regulations for hospital and medical services corporations are promulgated, a corporation must possess surplus in an amount which is the greater of \$5,000,000 or 8.0% of the total amount of premiums for insured risk received by the corporation in the preceding calendar year. The total amount of premiums for insured risk shall not include premiums collected for federal health benefit programs that have a separate reserve fund held by the federal government.

(b) The surplus requirement of 8.0% shall be phased-in following April 9, 1997 as follows:

(1) Year one — 40% of the surplus requirement in subsection (a) of this section;

(2) Year two — 60% of the surplus requirement in subsection (a) of this section;

(3) Year three — 80% of the surplus requirement in subsection (a) of this section; and

(4) Year four — 100% of the surplus requirement in subsection (a) of this section.

(c) The Mayor shall have the authority to require the differentiation of the corporation's activities into risk and nonrisk business for the purpose of determining the corporation's income that is derived from premiums for insured risk and from other sources.

(d) Notwithstanding the provisions of subsection (a) of this section, at the time of issuance of a certificate of authority under this chapter and at all times thereafter, a corporation shall be subject to the provisions of any risk-based capital regulations for hospital and medical services corporations promulgated by the Mayor, and must maintain at all times such surplus as is determined to be necessary under those regulations.

(e) The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business. The surplus may be considered excessive only if:

(1) The surplus is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

(2) After a hearing, the Commissioner determines that the surplus is unreasonably large and inconsistent with the corporation's obligation under § 31-3505(a).

(f) In determining whether the surplus of the corporation that is attributable to the District is excessive, the Commissioner shall take into account all of the corporation's financial obligations arising in connection with the conduct of the corporation's insurance business, including premium tax paid and the corporation's contribution to the open enrollment program required by § 31-3514 and payments and expenditures pursuant to a public-private partnership.

(g)(1) If the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner.

(2) A plan submitted pursuant to paragraph (1) of this subsection may consist entirely of expenditures for the benefit of current subscribers of the corporation.

(h) When determining what surplus is attributable to the District and whether the surplus is excessive, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation.

(i) If the Commissioner determines that the corporation failed to submit a plan as ordered under subsection (g) of this section within a reasonable period or failed to execute within a reasonable period a plan already submitted under subsection (g) of this section, the Commissioner shall deny for 12 months all premium rate increases for subscriber policies written in the District sought by the corporation pursuant to § 31-3508 and may issue such orders as are necessary to enforce the purposes of this chapter.

(j) The existence of a public-private partnership shall not preclude the Commissioner's surplus evaluation of the corporation or diminish the Commissioner's authority to issue directives to the corporation pursuant to the evaluation.

(Apr. 9, 1997, D.C. Law 11-245, § 7, 44 DCR 1158; Mar. 25, 2009, D.C. Law 17-369, § 2(d), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18-104, § 2(c), 56 DCR 9182.)

Prior Codifications. — 1981 Ed., § 35-4706.

Effect of amendments. — D.C. Law 17-369 added subsecs. (e), (f), (g), (h), and (i).

D.C. Law 18-104, in subsec. (e), substituted “The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall be undertaken in coordination with the other jurisdictions in which the corporation conducts business.” for “Within 120 days after March 25, 2009, and annually thereafter, the Commissioner shall review the portion of the surplus of the corporation that is attributable to the District and shall issue a determination as to whether the surplus is excessive.”; in subsec. (f), substituted “§ 31-3514 and payments and expenditures pursuant to a public-private partnership” for “§ 31-3514”; and added subsec. (j).

Temporary Amendment of Section. — Section 2 of D.C. Law 18-85, in subsec. (e), “180 days” for “120 days”.

Section 5(b) of D.C. Law 18-85 provided that the act shall expire after 225 days of its having taken effect.

Section 2(c) of D.C. Law 18-134, in subsec. (e), struck the first sentence and inserted “The Commissioner may, on an annual basis, and shall, on a basis no less frequently than every 3 years, review the portion of the surplus of the corporation that is attributable to the District and may issue a determination as to whether the surplus is excessive. Any such review shall

be undertaken in coordination with the other jurisdictions in which the corporation conducts business.”; in subsec. (f), substituted “section 15 and payments and expenditures pursuant to a public-private partnership” for “section 15”; and added subsec. (j) to read as follows:

“(j) The existence of a public-private partnership shall not preclude the Commissioner’s surplus evaluation of the corporation or diminish the Commissioner’s authority to issue directives to the corporation pursuant to the evaluation.”.

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Medical Insurance Empowerment Surplus Review Emergency Act of 2009 (D.C. Act 18-153, July 28, 2009, 56 DCR 6342).

For temporary (90 day) amendment of section, see § 2 of Medical Insurance Empowerment Surplus Review Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18-210, October 21, 2009, 56 DCR 8487).

For temporary (90 day) amendment of section, see § 2(c) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

Legislative history of Law 18-104. — For Law 18-104, see notes following § 31-205.

§ 31-3506.01. Compliance and implementation of community health reinvestment obligations.

(a) A corporation shall make available to the Commissioner such information as may be required to permit the Commissioner to verify the corporation’s community health reinvestment and, if appropriate, its compliance with its plan to dedicate excess surplus or to verify that the corporation is participating in a public-private partnership. When verifying the community health reinvestment or the corporation’s compliance with its plan, or when verifying the corporation’s participation in a public-private partnership the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation.

(b) In implementing the provisions of the Medical Insurance Empowerment

Amendment Act of 2008 [D.C. Law 17-369], the Commissioner shall consider the interests and needs of the jurisdictions in the corporation's service area.

(Apr. 9, 1997, D.C. Law 11-245, § 7a, as added Mar. 25, 2009, D.C. Law 17-369, § 2(e), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18-104, § 2(d), 56 DCR 9182.)

Effect of amendments. — D.C. Law 18-104 rewrote subsec. (a), which had read as follows: “(a) A corporation shall make available to the Commissioner such information as may be required to permit the Commissioner to verify the corporation's community health reinvestment and, if appropriate, its compliance with its plan to dedicate excess surplus. When verifying the community health reinvestment or the corporation's compliance with its plan, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals, the cost of which shall be borne by the corporation.”

Temporary Amendment of Section. — Section 2(d) of D.C. Law 18-134, in subsec. (a), substituted “dedicate excess surplus or to verify that the corporation is participating in a public-private partnership” for “dedicate excess sur-

plus” and substituted “or the corporation's compliance with its plan, or when verifying the corporation's participation in a public-private partnership” for “or the corporation's compliance with its plan.”

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2(d) of Hospital and Medical Services Corporation Regulatory Emergency Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

Legislative history of Law 18-104. — For Law 18-104, see notes following § 31-205.

§ 31-3507. Filing of provider contracts.

(a) A corporation holding a certificate of authority under this chapter may enter into contracts with licensed hospitals, licensed physicians, and other duly licensed medical services providers.

(b) A copy of each contract form that a corporation, referred to in subsection (a) of this section, has with licensed hospitals, licensed physicians, and other duly licensed medical services providers shall be filed with the Mayor.

(Apr. 9, 1997, D.C. Law 11-245, § 8, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4707.

Legislative history of Law 11-245. — For

legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

§ 31-3508. Filing of subscriber contract forms and rates.

(a) *Contract form filings.* —

(1) The form and content of all subscriber contracts between corporation and its contractholders issued in the District of Columbia, including any group certificates and any riders, endorsements, amendments, or other forms made a part of the subscriber contract, shall, at all times, be subject to the prior approval of the Mayor.

(2) The Mayor shall disapprove a proposed form of subscriber contract if the form contains provisions which are unjust, unfair, inequitable, inadequate, misleading, or deceptive, which encourage misrepresentation of the coverage, or which are otherwise not in compliance with applicable provisions of this chapter.

(3) Each subscriber contract, group certificate, or other contract form

shall plainly state the services, benefits, and indemnification to which the subscriber is entitled as well as the services, benefits, and indemnification to which the subscriber is not entitled.

(4) Each proposed form of a subscriber contract shall be on file for a waiting period of 60 days before it becomes effective. When, in the Mayor's opinion, a filing is not accompanied by the information needed to support it and the Mayor does not have sufficient information to determine whether the filing meets the requirements of this section, a corporation shall be required to furnish the needed information. In such event the waiting period shall be suspended and shall recommence as of the date the information is furnished. Upon written application by the corporation, the Mayor may authorize a filing which the Mayor has reviewed to become effective before the expiration of the waiting period or any extension thereof, or at any later date. A filing shall be deemed approved unless disapproved by the Mayor within the waiting period or any extension thereof requested by the corporation.

(b) *Rate filings for individual subscriber contracts.* — All rates for individual subscriber contracts issued in the District of Columbia shall be subject to the prior approval of the Mayor. Each proposed rate filing shall be on file for a waiting period of 60 days before it becomes effective. When, in the Mayor's opinion, a rate filing is not accompanied by the information needed to support it and the Mayor does not have sufficient information to determine whether the rate filing meets the requirements of this section, a corporation shall be required to furnish the needed information. In such event, the waiting period shall be suspended and shall recommence as of the date the information is furnished. Upon written application by the corporation, the Mayor may authorize a rate filing which the Mayor has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed approved unless disapproved by the Mayor within the waiting period or any extension thereof requested by the corporation. All approved rate filings for individual subscriber contracts submitted in other jurisdictions shall be filed with the Mayor for information purposes only.

(c) *Rate filings for group subscriber contracts.* — All rates for group subscriber contracts, other than experience rated groups, issued in the District of Columbia shall be filed with the Mayor no later than the date on which a corporation proposes to make such rates effective. The rate filing shall be subject to review and disapproval by the Mayor for a period of 60 days after the filing date. If not disapproved before the expiration of the review period or any extension thereof requested by the corporation, the filing shall be deemed approved. Any disapproval under this subsection shall be applied retrospectively to the date the corporation made such rates effective. Upon application by the corporation, the Mayor may affirmatively approve a filing prior to the end of the review period. All approved rate filings for group subscriber contracts, other than experience rated groups, submitted in other jurisdictions shall be filed with the Mayor for information purposes only.

(d) *Contract form and rate filings generally.* —

(1) Application for approval shall be made to the Mayor in the format, and with the information, that the Mayor requires.

(2) The Mayor may, at any time, require any corporation issued a certificate of authority under this chapter to demonstrate that its filings, including the terms and provisions of its subscriber contract forms, its rates, and its method for setting rates, are in compliance with this section, notwithstanding that the filings then in effect had previously been approved by the Mayor. Any subscriber contract forms and rates previously approved by the Mayor, but subsequently disapproved under this section, shall be considered disapproved on a prospective basis only from the date of such notice of disapproval, unless the corporation made a material misrepresentation in its contract form or rate filings.

(3) If at any time subsequent to the applicable waiting or review period provided for in this section, the Mayor finds that a filing does not meet the requirements of this section, the Mayor shall issue an order to the filer specifying in what respects the Mayor finds that the filing fails to meet the requirements of this section, and stating when, within a reasonable period thereafter, the filing shall be no longer effective. The order shall not affect any subscriber contract, group certificate, or other contract made or issued prior to the expiration of the period set forth in the order. However, the Mayor may, prior to issuing the order and if requested by the filer, hold a hearing upon not less than 10 days written notice to the filer specifying the matters to be considered at the hearing.

(e) *Rate filings generally.* —

(1) Rate filings shall be inclusive of all rates, rating plans, and other documents utilized by a corporation to determine rates.

(2) Rates shall not be excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered.

(3) In determining whether to disapprove a rate filing, the Mayor shall give due consideration to past and prospective loss experience within and outside the District of Columbia, to underwriting practice and judgment to the extent appropriate, to a reasonable margin for surplus needs, to past and prospective expenses both nationwide and within the District of Columbia, and to all other relevant factors within and outside the District of Columbia. In establishing the rates to be charged individuals with open enrollment subscriber contracts, including individual conversion subscriber contracts, the revenue which would have been otherwise collected by the District of Columbia government through the imposition of the 1% premium tax pursuant to § 31-3514(j), but which a corporation has contributed to a Rate Stabilization Fund in accordance with § 31-3514(j)(1), shall be credited by the corporation to the benefit of this class of subscribers in an amount which assures competitive rates.

(4) A corporation filing a rate pursuant to this section shall also comply with the Reasonable Health Insurance Ratemaking Reform Act of 2010 [D.C. Law 18-360].

(f) *Transition provision for contract forms and rates.* —

(1) As to any corporation heretofore existing and operating on April 9, 1997, and subject to § 31-3523, all subscriber contracts, group certificates, and other contracts issued in the District of Columbia after April 9, 1997, shall be

on forms that have been filed and approved under this chapter. The requirement of this section shall not affect the validity of subscriber contracts, group certificates, and other contracts issued in the District of Columbia by such a corporation which are outstanding on April 9, 1997, and have not previously been filed with and approved by the Mayor, but these contracts shall be replaced, at the next contract anniversary date following April 9, 1997, by forms filed and approved under this chapter.

(2) As to any corporation heretofore existing and operating on April 9, 1997, and subject to § 31-3523, all rates applied to subscriber contracts after April 9, 1997 shall be such rates as have been filed and approved under this chapter. The requirements of this section shall not affect the validity of rates applied to subscriber contracts issued by such a corporation which are outstanding on April 9, 1997, and have not previously been filed with and approved by the Mayor, but these rates shall be replaced, at the next contract anniversary date following April 9, 1997, by rates filed and approved under this chapter.

(g) A corporation whose proposed form of subscriber contract or proposed contract rate has been disapproved by the Mayor may contest the Mayor's action in accordance with the procedures of § 31-3522.

(Apr. 9, 1997, D.C. Law 11-245, § 9, 44 DCR 1158; Apr. 8, 2011, D.C. Law 18-360, § 503(b), 58 DCR 896.)

Prior Codifications. — 1981 Ed., § 35-4708.

Effect of amendments. — D.C. Law 18-360 added subsec. (e)(4).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3 of Reasonable Health Insurance Premium Increase Emergency Amendment Act of 2010 (D.C. Act 18-328, March 18, 2010, 57 DCR 2546).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

§ 31-3509. Reserves.

(a) Taking into consideration the nature of the policies issued by the corporation, a corporation shall establish and maintain pro rata gross unearned premium reserves, reserves for incurred but unpaid claims (both reported and unreported), reserves for expenses related to settlement of such claims, and other reserves as required for proper reporting of its financial condition or as required under the form of financial statements required of the corporation.

(b) The reserves required under subsection (a) of this section constitute a liability of the corporation in a determination of its financial condition.

(Apr. 9, 1997, D.C. Law 11-245, § 10, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4709.

Legislative history of Law 11-245. — For

legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

§ 31-3510. Investments.

Notwithstanding any provision of § 31-4435 [repealed], as made applicable by § 31-3503(8), and notwithstanding any other provision of this chapter:

(1) Without the Mayor's prior written consent, a corporation's aggregate investments in real estate pursuant to § 31-4435(d)(1)(A) through (F) [repealed], shall not at any time exceed 20% of the amount of the corporation's admitted assets as reported on the corporation's annual financial statement most recently filed with the Mayor.

(2) A corporation's investments in real estate pursuant to § 31-4435(d)(1)(A) through (F) [repealed], shall in no event exceed the actual cost plus the capitalized value (less normal depreciation) of the permanent improvements.

(3) For real estate owned by a corporation pursuant to § 31-4435(d)(1)(A) [repealed] on April 9, 1997, the corporation may, as its option, determine admitted asset value in accordance with an appraisal most recently conducted prior to April 9, 1997; provided, that the appraisal is acceptable to the Mayor. The difference between the admitted asset value as so identified and the book value (equal to the historical cost, less the value of encumbrances and accumulated depreciation) shall be accounted for as an unrealized gain and credited to reserves and unassigned funds and shall be amortized and charged to reserves and unassigned funds. Thereafter, such real estate shall be valued, for purposes of the financial statements required by § 31-1901, at such appraised value, less accumulated amortization, plus the capitalized value of permanent improvements, less normal depreciation. Normal depreciation on the capitalized value of permanent improvements shall be charged as an expense in the underwriting and investment exhibit to the corporation's annual financial statement.

(4) A corporation shall not invest in or otherwise acquire any affiliate or subsidiary, as those terms are defined in § 31-701, except in accordance with the following:

(A) The business of the affiliate or subsidiary must be directly related to the operation of the corporation or the administration of a health benefits program.

(B)(i) The corporation must submit a statement of proposed action to the Mayor before the corporation:

(I) Creates, invests in, or otherwise acquires any affiliate or subsidiary; or

(II) Alters the legal structure, purpose, or ownership of the corporation or any affiliate or subsidiary of the corporation.

(ii) The statement of proposed action required under this subparagraph shall be filed by the corporation not less than 30 days prior to the effective date of the proposed action.

(iii) The statement of proposed action shall be deemed approved unless disapproved by the Mayor within the 30-day waiting period or any extension thereof requested by the corporation.

(iv) The corporation shall not be required to submit a statement of proposed action to the Mayor under this subparagraph when the proposed

action is required to be reported to the Mayor pursuant to Chapter 7 of this title.

(Apr. 9, 1997, D.C. Law 11-245, § 11, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4710. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For

§ 31-3511. Surplus notes.

(a) A domestic corporation may borrow or assume a liability for the repayment of a sum of money under a written agreement which provides that the loan or advance shall be repaid only out of surplus of the corporation in excess of such minimum surplus as is stipulated in and by the agreement and if the surplus of the corporation after such payment would meet or exceed the level of surplus the corporation is required to maintain by the Mayor under the laws or regulations of the District of Columbia. The rate of interest specified in such an agreement may be adjusted no more frequently than annually to provide for a rate not exceeding the one-year treasury bill rate plus 3% at the time of adjustment. At the time the loan or advance is made, the interest rate shall not exceed the one-year treasury bill rate plus 3% annum.

(b) Subject to approval by the Mayor, the interest rate on all loans or advances existing on April 9, 1997 can be amended to the rate as permitted in this section with the mutual agreement of the corporation and the lender.

(c) A domestic corporation shall, before entering into an agreement for a loan or advance permitted under this section, file with the Mayor a statement of the purpose of the loan or advance and a copy of the proposed agreement. The Mayor shall disapprove any proposed agreement for a loan or advance if the Mayor finds that the loan or advance is unnecessary or excessive for the purpose intended; that the terms of the agreement are not fair and equitable to the parties and to other lenders, if any, to the corporation; that the information so filed by the corporation is inadequate; or that the terms of the agreement are not otherwise in compliance with this section.

(d) Any loan or advance to a domestic corporation shall be repaid by the corporation when, and to the extent, no longer reasonably necessary for the purpose originally intended; provided, that no repayment of such a loan or advance shall be made unless approved in advance by the Mayor.

(e) Nothing in this section shall be construed to mean that a corporation may not borrow money otherwise than by a loan or advance, but the amount so borrowed with accrued interest thereon shall be carried by the corporation as a liability.

(Apr. 9, 1997, D.C. Law 11-245, § 12, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4711. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For

§ 31-3512. Group subscriber contract standard provisions.

No group subscriber contract shall be issued in the District of Columbia by a corporation unless it contains in substance the following provisions, or provisions which in the opinion of the Mayor are more favorable to the subscribers, or at least as favorable to the subscribers and more favorable to the group contractholder; except, that if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of contract, the corporation, with the approval of the Mayor, shall omit from such contract any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the contract consistent with the coverage provided by the contract:

(1) A provision that the group contractholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the contract shall continue in force, unless the group contractholder has given the corporation written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the contract; except, that the contract may provide that the contractholder shall be liable to the corporation for the payment of a pro rata premium for the time the contract was in force during such grace period;

(2) A provision that the validity of the contract shall not be contested except for nonpayment of premiums, fraudulent misstatements, noncompliance with contractual provisions and noncompliance with eligibility requirements after it has been in force for 2 years from its date of issue;

(3) A provision that no statement made by any subscriber under the contract relating to insurability may be used in contesting the validity of the coverage with respect to which such statement was made after the subscriber's coverage has been in force for a period of 2 years nor unless it is contained in a written instrument signed by the subscriber, except that this provision need not preclude the assertion at any time of defenses based upon the subscriber's lack of eligibility for coverage under the contract or upon other provisions in the contract unrelated to insurability;

(4) A provision that a copy of the application, if any, of the contractholder shall be attached to the contract when issued, that all statements made by the contractholder or by the subscriber shall be deemed representations and not warranties, and that no statement made by any subscriber may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the subscriber, to the individual's beneficiary or personal representative;

(5) A provision setting forth the conditions, if any, under which the corporation reserves the right to require a person eligible for coverage to furnish evidence of individual insurability satisfactory to the corporation as a condition to part or all of the individual's coverage;

(6) A provision that the corporation shall issue to the contractholder for delivery to each subscriber a certificate setting forth a statement as to the

coverage to which that person is entitled, to whom benefits are payable, and a statement as to any family member's or dependent's coverage;

(7) A provision that written notice of a claim must be given to the corporation within 15 months after the occurrence or commencement of the date of a service covered by the contract and that failure to give notice within such time shall not invalidate or reduce any claim if it is shown that the contractholder was legally incapacitated prior to the expiration of the 15-month claim filing period;

(8) A provision that the corporation shall furnish to the subscriber under the contract, or to the contractholder for delivery to the subscriber, such forms as are usually furnished by it for filing a claim; and that if such forms are not furnished before the expiration of 20 days after the corporation received notice of any claim under the contract, the person making the claim shall be deemed to have complied with the claims filing requirements of the contract;

(9) A provision that all benefits and indemnification payable under the contract must be paid not more than 60 days after receipt of all necessary information and documentation or proof;

(10) A provision that the corporation has the right to examine the person for whom a claim is so filed under the contract as often as it may reasonably require during the pendency of the claim and also has the right to conduct an autopsy in case of death if doing so is not prohibited by law;

(11) A provision that no action at law or in equity may be brought to recover on the contract before the expiration of 60 days from the date a claim has been filed in accordance with the claim filing requirements of the contract or after a period of 3 years from the last date on which a claim is required to be filed under the claim filing requirements of the contract; and

(12) A provision that allows subscribers who leave such groups to convert, without evidence of insurability, to an individual subscriber contract providing an adequate level of coverage and in accordance with any standards the Mayor prescribes pursuant to § 31-3514(g).

(Apr. 9, 1997, D.C. Law 11-245, § 13, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4712.

legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For

§ 31-3513. Reports.

(a) In addition to the annual statement required by § 31-1901, the Mayor:

(1) May require each corporation to file on a quarterly or other basis any additional reports, exhibits, or statements the Mayor considers necessary to furnish all information concerning the condition, solvency, experience, transactions, or affairs of the corporation. The Mayor may establish deadlines for submitting any additional reports, exhibits, or statements and may require their verification by any officer or officers of the corporation the Mayor designates; and

(2) Shall require each corporation to file annually, on or before June 1, a report, signed by 2 of its principal officers, showing:

(A) The number of the District of Columbia contractholders and subscribers by the following type of contract or its equivalent:

- (i) Individual, open enrollment;
- (ii) Individual conversion subscribers;
- (iii) Group subscribers, as defined by regulation;
- (iv) Medigap and Medicare supplements; and
- (v) Associations;

(B) Total subscriber income, benefit, and indemnification payments for the types of contracts listed in paragraph (1) of this subsection, with a specific breakdown by type of contract if requested by the Mayor; and

(C) Expenditures for providing public services, in addition to open enrollment, in the District of Columbia.

(Apr. 9, 1997, D.C. Law 11-245, § 14, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4713.

legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-

Legislative history of Law 11-245. — For 3501.

§ 31-3514. Open enrollment.

(a) A corporation issued a certificate of authority under this chapter shall make available to citizens of the District of Columbia an open enrollment program under the terms set forth in this section.

(b) As used in this section, the term:

(1) “Comprehensive individual subscriber contracts” means subscriber contracts, conforming to the requirements of subsection (g) of this section, which are issued to provide basic hospital and medical services, or to provide benefits and indemnification for such services.

(2) “Open enrollment subscriber contracts” means comprehensive individual subscriber contracts issued pursuant to an open enrollment program by a corporation which has a certificate of authority under this chapter and provides coverage to individuals.

(c) A corporation’s open enrollment program shall provide for the issuance of open enrollment subscriber contracts without imposition by the corporation of underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal, in whole or in part, because of an individual’s age, health history, medical history, employment status, or, if employed, industry or job classification.

(d) A corporation’s open enrollment program shall make open enrollment subscriber contracts available to any individual residing in the District of Columbia, except, that this requirement shall not apply to any individual who is eligible for coverage as an employee of an employer which provides, in whole or in part, basic hospital and medical services, benefits, and indemnification coverage to its employees.

(e) A corporation’s open enrollment program shall be available on a year-round basis.

(f) Repealed.

(g) The Mayor may prescribe minimum standards to govern the contents of

comprehensive individual subscriber contracts issued pursuant to this section. Such minimum standards shall ensure that these contracts provide hospital and medical services, or benefits and indemnification for a comprehensive range of health care needs without qualifying exclusions that fail to protect the subscriber under normal circumstances. Such minimum standards shall also ensure that the option of obtaining comprehensive individual subscriber contract coverage is made available to all individuals included within the definition of “open enrollment subscriber contracts” in subsection (b)(2) of this section.

(h) The Mayor may prescribe minimum standards specifically to govern the content of comprehensive individual subscriber contracts issued to individuals who have converted from group subscriber contracts to individual coverage because of termination of the individual’s eligibility for group coverage.

(i) A corporation issued a certificate of authority under this chapter shall provide other public services in the District of Columbia consisting of health-related educational support for residents of the corporation’s service area who, based upon such educational support, may experience a lesser need for hospital and medical services, or benefits and indemnification for such services.

(j)(1) A corporation shall maintain a separately established rate stabilization fund (“RS Fund”) to be used solely to subsidize open enrollment subscribers pursuant to subsections (c) and (d) of this section. A corporation shall deposit an amount necessary and appropriate to maintain the open enrollment program of the corporation pursuant to subsection (k)(1) of this section; provided, that the corporation shall not deduct an aggregate amount exceeding \$550,000 of its payment to the RS Fund from the amount otherwise due by the corporation under § 31-205 or § 47-2608(a). The RS Fund shall not be used to pay marketing or promotional expenses associated with the program. Unless the corporation elects to terminate the RS Fund pursuant to subsection (k)(3) of this section, the corporation shall carry over from year to year all unexpended funds in the RS Fund, including interest earned on investment of the funds in the RS Fund.

(2) In the rate filings for the open enrollment program required by § 31-3508, a corporation shall provide documentation to the Mayor confirming the existence of the RS Fund, identifying the amounts paid from the RS Fund to subsidize open enrollment rates, and specifying the RS Fund balance at year end and as of the date of the corporation’s filing. The Mayor shall order annually an independent audit of the RS Fund, the expenses of which shall be paid by the corporation. If the Mayor determines, with or without an audit, that all or any portion of the money in the RS Fund is not being used to subsidize open enrollment rates or is not being reasonably set aside in anticipation of projected subsidies of open enrollment rates in future years, the Mayor may order the corporation to pay the revenue not being so used or set aside to the Healthy DC and Health Care Expansion Fund established by § 31-3514.02.

(k) A corporation shall continue to offer the program to each subscriber as long as the subscriber renews his or her coverage under the program.

(l) Any proposed rates filed by a corporation with the Mayor pursuant to § 31-3508 which are to be applied to open enrollment subscriber contracts, including individual conversion subscriber contracts, shall include a factor crediting for the benefit of this class of subscribers in an amount which assures competitive rates, the revenue which would have been otherwise collected by the District of Columbia government as a premium tax pursuant to § 31-3514(j).

(m) The open enrollment program shall maintain the following affordability and adequacy criteria for individual participants:

(1) Annual premium costs shall not exceed 125% of standard individual market rates and shall be determined once every 12 months.

(2) Cost sharing, deductibles, and co-insurance shall not exceed those in the corporation's most popular policy available to small employers in the District.

(3) Subscriber contracts shall not contain service limitations or lifetime or annual benefit maximums.

(4) Subscriber contracts and contract forms shall be subject to § 31-3508.

(5) Subscriber contracts and contract forms shall not contain exclusions or riders for pre-existing conditions.

(n) A corporation shall prominently advertise the availability of its open enrollment subscriber contracts continuously on the Internet and at least quarterly in a newspaper of general circulation throughout the District. The content and format of the advertising shall be filed with the Commissioner no less than 30 days before its appearance in a newspaper or on the Internet.

(o) The corporation shall make the open enrollment program available for a minimum of 2500 subscribers. The corporation shall submit a report annually on October 1 to the Commissioner on the number of subscribers enrolled.

(p) In lieu of the requirements of subsection (m) through (o) of this section, the corporation may enter into a public-private partnership.

(q) The corporation shall submit an annual report to the Mayor regarding the open enrollment program. The Mayor shall determine the format and content of the report; provided, that the report shall include:

(1) Membership distribution by:

(A) Age;

(B) Gender;

(C) Ward;

(D) Zip code;

(E) Race/ethnicity;

(F) Income; and

(G) The amount of time in the program;

(2) The number of members by contract type;

(3) Program expenditures for:

(A) Inpatient services;

(B) Outpatient services;

(C) Behavioral health services; and

(D) Prescription drugs;

(4) Average premium;

- (5) Premium levels by age; and
- (6) The number of members that have reached the:
 - (A) Out-of-pocket maximum expenditure; and
 - (B) Annual prescription drug benefit maximum.

(r) The public-private partnership shall be certified by January 31, 2010.

(Apr. 9, 1997, D.C. Law 11-245, § 15, 44 DCR 1158; June 11, 2004, D.C. Law 15-166, § 4(u)(3), 51 DCR 2817; Mar. 2, 2007, D.C. Law 16-192, § 5012(b), 53 DCR 6899; Mar. 25, 2009, D.C. Law 17-369, § 2(f), 56 DCR 1346; Feb. 4, 2010, D.C. Law 18-104, § 2(e), 56 DCR 9182; Sept. 24, 2010, D.C. Law 18-223, § 5023(b), 57 DCR 6242.)

Prior Codifications. — 1981 Ed., § 35-4714.

Effect of amendments. — D.C. Law 15-166, in par. (3) of subsec. (j), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation” both times it appears.

D.C. Law 16-192 repealed subsec. (f) and rewrote subssecs. (j) and (k).

D.C. Law 17-369, in subsec. (j)(2), substituted “shall order annually an independent” for “may order an independent”; rewrote subsec. (k); and added subssecs. (m), (n), and (o).

D.C. Law 18-104 added subssecs. (p), (q) and (r).

D.C. Law 18-223, in subsec. (j)(2), substituted “Healthy DC and Health Care Expansion Fund” for “Healthy DC Fund”.

Temporary Amendment of Section. — Section 2(e) of D.C. Law 18-134 added subssecs. (p), (q), and (r) to read as follows:

“(p) In lieu of the requirements of subsection (m) through (o) of this section, the corporation may enter into a public-private partnership.

“(q) The corporation shall submit an annual report to the Mayor regarding the open enrollment program. The Mayor shall determine the format and content of the report; provided, that the report shall include:

“(1) Membership distribution by:

“(A) Age

“(B) Gender;

“(C) Ward;

“(D) Zip code;

“(E) Race/ethnicity;

“(F) Income; and

“(F) The amount of time in the program;

“(2) The number of members by contract type;

“(3) Program expenditures for:

“(A) Inpatient services;

“(B) Outpatient services;

“(C) Behavioral health services; and

“(D) Prescription drugs;

“(4) Average premium;

“(5) Premium levels by age; and

“(6) The number of members that have reached the:

“(A) Out-of-pocket maximum expenditure; and

“(B) Annual prescription drug benefit maximum.

“(r) The public-private partnership shall be certified by January 31, 2010.”

Section 6(b) of D.C. Law 18-134 provided that the act shall expire after 225 days of its having taken effect.

Section 3(b) of D.C. Law 18-205, in subsec. (j)(2), substituted “Healthy DC and Health Care Expansion Fund” for “Healthy DC Fund”.

Section 7(b) of D.C. Law 18-205 provided that the act shall expire after 225 days of its having taken effect.

Section 201(b) of D.C. Law 18-271, in subsec. (d), substituted “District of Columbia who is ineligible for the DC High Risk Pool Program,” for “District of Columbia.”

Section 301(b) of D.C. Law 18-271 provided that the act shall expire after 225 days of its having taken effect.

Temporary Addition of Section. — Section 3 of D.C. Law 18-85 added a section to read as follows: “Sec 2a. Applicability. ”Section 2(f) shall not apply until 90 days after the Commissioner completes his surplus review as required by section 2(e) and transmits a copy of the determination to the Council. This section shall apply as of March 25, 2009.”

Section 5(b) of D.C. Law 18-85 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(u)(3) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) amendment of section, see § 5012(b) of Fiscal Year 2007 Budget Support Emergency Act of 2006 (D.C. Act 16-477, August 8, 2006, 53 DCR 7068).

For temporary (90 day) enactments, see § 5012(c) of Fiscal Year 2007 Budget Support Emergency Act of 2006 (D.C. Act 16-477, August 8, 2006, 53 DCR 7068).

For temporary (90 day) amendment of section, see § 5012(b) of Fiscal Year 2007 Budget

Support Congressional Review Emergency Act of 2006 (D.C. Act 16-499, October 23, 2006, 53 DCR 8845).

For temporary (90 day) enactments, see § 5012(c) of Fiscal Year 2007 Budget Support Congressional Review Emergency Act of 2006 (D.C. Act 16-499, October 23, 2006, 53 DCR 8845).

For temporary (90 day) amendment of section, see § 5012(b) of Fiscal Year 2007 Budget Support Congressional Review Emergency Act of 2007 (D.C. Act 17-1, January 16, 2007, 54 DCR 1165).

For temporary (90 day) applicability provision, see § 2 of Medical Insurance Empowerment Emergency Amendment Act of 2009 (D.C. Act 18-51, April 29, 2009, 56 DCR 3586).

For temporary (90 day) addition, see § 3 of Medical Insurance Empowerment Surplus Review Emergency Act of 2009 (D.C. Act 18-153, July 28, 2009, 56 DCR 6342).

For temporary (90 day) addition, see § 3 of Medical Insurance Empowerment Surplus Review Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18-210, October 21, 2009, 56 DCR 8487).

For temporary (90 day) amendment of section, see § 2(e) of Hospital and Medical Services Corporation Regulatory Emergency

Amendment Act of 2009 (D.C. Act 18-277, January 11, 2010, 57 DCR 935).

For temporary (90 day) amendment of section, see § 3(b) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18-390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 201(b) of DC High Risk Pool Program Establishment Emergency Act of 2010 (D.C. Act 18-522, August 3, 2010, 57 DCR 8001).

For temporary (90 day) amendment of section, see § 5023(b) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 16-192. — For Law 16-192, see notes following § 31-205.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

Legislative history of Law 18-104. — For Law 18-104, see notes following § 31-205.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

§ 31-3514.01. Tax and related payments.

A corporation shall be subject to § 47-2608.

(Apr. 9, 1997, D.C. Law 11-245, § 15a, as added Mar. 2, 2007, D.C. Law 16-192, § 5012(c), 53 DCR 6899.)

Legislative history of Law 16-192. — For Law 16-192, see notes following § 31-205.

§ 31-3514.02. Establishment of Healthy DC and Health Care Expansion Fund.

(a) There is established as a nonlapsing fund the Healthy DC and Health Care Expansion Fund ("Fund"). All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available to support the Healthy DC Program, established by Chapter 6A of Title 4, and other medical assistance programs administered by the Department of Health Care Finance, without regard to fiscal year limitation, subject to authorization by Congress.

(b) There shall be deposited into the Fund:

(1) All tax revenue generated pursuant to § 31-3514.01;

(2) Any other local funds, including any fees, penalties, or other tax revenues required by District law, including the premium tax imposed on health maintenance organizations, as required by § 31-3403.01.

- (3) Annual appropriations, if any;
- (4) Federal grant funds;
- (5) All fines and penalties collected pursuant to Chapter 6A of Title 4; and
- (6) Grants, gifts, or subsidies from public or private sources.

(c) Notwithstanding subsection (a) of this section, for fiscal year 2010, up to \$3.25 million from the Fund shall be utilized to support the following one-time allocations:

(1) An amount of \$2.5 million shall support a grant to an acute care pediatric hospital in the District for the purpose of supporting operational expenses associated with the new pediatric emergency facility located at the United Medical Center; and

(2) Up to \$750,000 to support operational expenses associated with the delivery of health care services at the D.C. Jail.

(Apr. 9, 1997, D.C. Law 11-245, § 15b, as added Mar. 2, 2007, D.C. Law 16-192, § 5012(c), 53 DCR 6899; Aug. 16, 2008, D.C. Law 17-219, § 5050, 55 DCR 7598; Mar. 25, 2009, D.C. Law 17-353, § 138, 56 DCR 1117; Mar. 3, 2010, D.C. Law 18-111, § 5131, 57 DCR 181; Sept. 24, 2010, D.C. Law 18-223, § 5023(c), 57 DCR 6242.)

Effect of amendments. — D.C. Law 17-219 rewrote the section.

D.C. Law 17-353 validated a previously made technical correction.

D.C. Law 18-111 added subsec. (c).

D.C. Law 18-223, in the section heading, substituted “Healthy DC and Health Care Expansion Fund” for “Healthy DC Fund”; in subsec. (a), substituted “Healthy DC and Health Care Expansion Fund (‘Fund’)” for “Healthy DC Fund (‘Fund’)” and inserted “, and other medical assistance programs administered by the Department of Health Care Finance,”; and rewrote subsec. (b)(2), which had read as follows: “(2) Any other local funds, including any fees, penalties, or other tax revenue required by District law, including a portion of the premium tax imposed on health maintenance organizations, as required by Chapter 34 of this title;”

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 202 of (D.C. Law 17-326, March 21, 2009, law notification 56 DCR 3037).

Section 2 of D.C. Law 18-154, in subsec. (a), substituted “, and any other purpose as set forth in this section, without regard” for “without regard”; and added subsec. (c) to read as follows:

“(c)(1) Notwithstanding subsection (a) of this section, the Mayor is authorized to utilize, in fiscal year 2010, up to \$5.9 million from the Fund to support the delivery of acute care services for uninsured or under-insured individuals at United Medical Center; provided, that:

“(A) An amount of \$3 million be distributed by March 2, 2010; and

“(B) Up to \$2.9 million be distributed, in equal monthly installments, beginning by March 15, 2010, and continuing through to September 30, 2010.

“(2) United Medical Center shall submit a quarterly report to the Mayor providing an accounting of any funds received pursuant to this subsection, including a detailed account of the acute care services that were provided.

“(3)(A) The Mayor shall seek to recoup any funds from United Medical Center that the Mayor determines were expended contrary to the authority granted by this subsection.

“(B) The Mayor may conduct an audit of the uncompensated acute care expenditures, if necessary, to verify that the funds were expended in accordance with this subsection.

“(4) The Department of Health Care Finance shall have grant-making authority for purposes of effectuating this subsection.”.

Section 8(b) of D.C. Law 18-154 provided that the act shall expire after 225 days of its having taken effect.

Section 3(c) of D.C. Law 18-205, in the section heading, substituted “Healthy DC and Health Care Expansion Fund” for “Healthy DC Fund”; in subsec. (a), substituted “Healthy DC and Health Care Expansion Fund (‘Fund’)” for “Healthy DC Fund (‘Fund’)” and substituted “Title 4, and other medical assistance programs administered by the Department of Health Care Finance, without” for “Title 4 without”; and rewrote subsec. (b)(2) to read as follows:

“(2) Any other local funds, including any fees, penalties, or other tax revenues required by District law, including the premium tax imposed on health maintenance organizations, as

required by section 4a of the Health Maintenance Organization Act of 1996, effective August 16, 2008 (D.C. Law 17-219; D.C. Official Code § 31-3403.01)."

Section 7(b) of D.C. Law 18-205 provided that the act shall expire after 225 days of its having taken effect.

Emergency legislation. — For temporary (90 day) enactment, see § 5012(c) of Fiscal Year 2007 Budget Support Congressional Review Emergency Act of 2007 (D.C. Act 17-1, January 16, 2007, 54 DCR 1165).

For temporary (90 day) amendment of section, see § 202 of Fiscal Year 2009 Balanced Budget Support Emergency Amendment Act of 2008 (D.C. Act 17-572, December 2, 2008, 55 DCR 12452).

For temporary (90 day) amendment of section, see § 202 of Fiscal Year 2009 Balanced Budget Support Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18-13, February 23, 2009, 56 DCR 1920).

For temporary (90 day) amendment of section, see § 5131 of Fiscal Year 2010 Budget Support Second Emergency Act of 2009 (D.C. Act 18-207, October 15, 2009, 56 DCR 8234).

For temporary (90 day) amendment of section, see § 5131 of Fiscal Year Budget Support Congressional Review Emergency Amendment Act of 2009 (D.C. Act 18-260, January 4, 2010, 57 DCR 345).

For temporary (90 day) amendment of section, see § 2 of Healthy DC Equal Access Fund and Hospital Stabilization Emergency Amendment Act of 2009 (D.C. Act 18-310, February 18, 2010, 57 DCR 1635).

For temporary (90 day) amendment of section, see § 3(c) of Medicaid Resource Maximization Emergency Amendment Act of 2010 (D.C. Act 18-390, May 7, 2010, 57 DCR 4339).

For temporary (90 day) amendment of section, see § 5023(c) of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 16-192. — For Law 16-192, see notes following § 31-205.

Legislative history of Law 17-219. — For Law 17-219, see notes following § 31-3403.01.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

Legislative history of Law 18-111. — Law 18-111, the "Fiscal Year 2010 Budget Support Act of 2009", was introduced in Council and assigned Bill No. 18-203, which was referred to the Committee on the Whole. The bill was adopted on first and second readings on May 12, 2009, and September 22, 2009, respectively. Signed by the Mayor on December 18, 2009, it was assigned Act No. 18-255 and transmitted to both Houses of Congress for its review. D.C. Law 18-111 became effective on March 3, 2010.

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-101.

Short title. — Short title: Section 5049 of D.C. Law 17-219 provided that subtitle S of title V of the act may be cited as the "Hospital and Medical Services Corporation Regulatory Act Amendment Act of 2008".

Short title: Section 5130 of D.C. Law 18-111 provided that subtitle N of title V of the act may be cited as the "Hospital and Medical Services Corporation Regulatory Amendment Act of 2009".

§ 31-3515. Conversion to a for-profit entity.

A corporation issued a certificate of authority under this chapter shall not be converted into a stock corporation, partnership, limited liability company, or other business entity organized for profit.

(Apr. 9, 1997, D.C. Law 11-245, § 16, 44 DCR 1158; Apr. 11, 2003, D.C. Law 14-297, § 401(c), 50 DCR 330; Dec. 9, 2003, D.C. Law 15-56, § 3(a), 50 DCR 9188; Mar. 25, 2009, D.C. Law 17-369, § 2(g), 56 DCR 1346.)

Prior Codifications. — 1981 Ed., § 35-4715.

Effect of amendments. — D.C. Law 14-297 rewrote subsec. (b)(2) which had read as follows: "(2) Fails to comply with §§ 31-4405, 31-4410 through 31-4415, 31-4421, 31-4424, 31-4428, 31-4431, and 31-4441;"

D.C. Law 15-56, in subsec. (b), substituted "company not involving a nonprofit hospital service plan or medical service plan unless" for "company unless", and added subsec. (b-1).

D.C. Law 17-369 rewrote the section.

Temporary Amendment of Section. —

For temporary (225 day) amendment of section, see § 3(a) of Department of Insurance and Securities Regulation Merger Review Temporary Amendment Act of 2002 (D.C. Law 14-217, March 25, 2003, law notification 50 DCR 2730).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(a) of Department of Insurance and Securities Regulation Merger Review Emergency Amendment Act of 2002 (D.C. Act 14-457, July 23, 2002, 48 DCR 8132).

For temporary (90 day) amendment of section, see § 3(a) of Department of Insurance and

Securities Regulation Merger Review Congressional Review Emergency Amendment Act of 2002 (D.C. Act 14-513, October 23, 2002, 49 DCR 10475).

For temporary (90 day) amendment of section, see § 3(a) of Department of Insurance and Securities Regulation Merger Review Congressional Review Emergency Amendment Act of 2003 (D.C. Act 15-8, January 27, 2003, 50 DCR 1473).

For temporary (90 day) amendment of section, see § 3(a) of Department of Insurance and Securities Regulation Merger Review Emergency Amendment Act of 2003 (D.C. Act 15-205, October 24, 2003, 50 DCR 9845).

For temporary (90 day) amendment of section, see § 3(a) of Department of Insurance and Securities Regulation Merger Review Second Congressional Review Emergency Amendment Act of 2003 (D.C. Act 15-257, November 25, 2003, 50 DCR 11006).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Legislative history of Law 15-56. — Law 15-56, the “Department of Insurance and Securities Merger Review Amendment Act of 2003”, was introduced in Council and assigned Bill No. 15-18, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on July 8, 2003, and September 16, 2003, respectively. Signed by the Mayor on October 6, 2003, it was assigned Act No. 15-175 and transmitted to both Houses of Congress for its review. D.C. Law 15-56 became effective on December 9, 2003.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

§ 31-3516. Conversion to a mutual company.

A corporation issued a certificate of authority under this chapter shall not be converted into a mutual insurance company.

(Apr. 9, 1997, D.C. Law 11-245, § 17, 44 DCR 1158; Dec. 9, 2003, D.C. Law 15-56, § 3(b), 50 DCR 9188; Mar. 25, 2009, D.C. Law 17-369, § 2(h), 56 DCR 1346.)

Prior Codifications. — 1981 Ed., § 35-4716.

Effect of amendments. — D.C. Law 15-56, in subsec. (b), substituted “company not involving a nonprofit hospital service plan or medical service plan unless” for “company unless”, and added subsec. (b-1).

D.C. Law 17-369 rewrote the section.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Temporary Amendment Act of 2002 (D.C. Law 14-217, March 25, 2003, law notification 50 DCR 2730).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Emergency Amendment Act of 2002 (D.C. Act 14-457, July 23, 2002, 48 DCR 8132).

For temporary (90 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Congressional Review Emergency Amendment Act of 2002 (D.C. Act 14-513, October 23, 2002, 49 DCR 10475).

For temporary (90 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Congressional Review Emergency Amendment Act of 2003 (D.C. Act 15-8, January 27, 2003, 50 DCR 1473).

For temporary (90 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Emergency Amendment Act of 2003 (D.C. Act 15-205, October 24, 2003, 50 DCR 9845).

For temporary (90 day) amendment of section, see § 3(b) of Department of Insurance and Securities Regulation Merger Review Second Congressional Review Emergency Amendment Act of 2003 (D.C. Act 15-257, November 25, 2003, 50 DCR 11006).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 15-56. — For Law 15-56, see notes following § 31-3515.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

§ 31-3517. Management contracts and service agreements.

(a) Any management contract or service agreement which delegates to any person or organization all or part of a substantial management duty, function, or other form of control of a corporation, such as adjustment of claims, production of business, investment of assets, or general servicing of the corporation's business, must be filed with the Mayor at least 30 days before the effective date of the contract or agreement.

(b) This requirement in subsection (a) of this section shall not apply to personal services contracts of executives of a corporation. Nor shall that requirement apply to contracts by groups of affiliated companies for shared services, such as maintenance, security, purchasing, and the like, where costs to the individual member companies are charged on an actually incurred or pro rata basis, except that these contracts shall be in writing.

(c) The Mayor shall disapprove any management contract or service agreement filed pursuant to subsection (a) of this section if, at any time, the Mayor finds one or more of the following:

(1) That the service or management charges are based upon criteria unrelated either to the managed corporation's profits or the reasonable, customary, and usual charges for such services, or are based on factors unrelated to the value of such services to the corporation;

(2) That management personnel or other employees of the corporation are to perform functions and receive any remuneration therefor under the management contract or service agreement in addition to the compensation received by way of salary for their services directly from the corporation;

(3) That the management contract or service agreement would transfer:

(A) Substantial control of the corporation or the basic functions of the corporation's management; or

(B) Any of the powers vested in the board of directors or trustees by statute, the corporation's articles of incorporation, or its bylaws;

(4) That the management contract or service agreement contains provisions which would be clearly detrimental to the best interests of contractholders or subscribers of the corporation; or

(5) That the officers, directors, or trustees of the contractor under the management contract or service agreement are of bad character or have been affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with any person or persons who have been involved in the improper manipulation of assets, accounts, or reinsurance.

(d) If the Mayor disapproves any management contract or service agreement filed pursuant to subsection (a) of this section, written notice of the reason for such action shall be given to the corporation, which may contest the Mayor's action in accordance with the procedures in § 31-3522.

(e) Any amendments to a management contract or service agreement shall be filed with the Mayor at least 30 days before they become effective. Any change in the officers, directors, or trustees of the contractor under a manage-

ment contract or service agreement shall be reported to the Mayor within 10 days after such change occurs. Upon review of such amendments and changes, the Mayor may disapprove the management contract or service agreement in accordance with the provisions of subsections (c) and (d) of this section.

(f) Any management contract or service agreement filed pursuant to subsection (a) of this section, and any amendment thereto, shall be deemed approved unless disapproved by the Mayor within 30 days after it is filed with the Mayor.

(Apr. 9, 1997, D.C. Law 11-245, § 18, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4717. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For 3501.

§ 31-3518. Directors and trustees.

Notwithstanding § 31-706(c)(3), or any other provision of District of Columbia insurance law referenced in § 31-3503, the following provisions shall apply to a domestic corporation issued a certificate of authority under this chapter:

(1) The board of directors or trustees shall consist of not less than 5 nor more than 21 members, who shall be elected by a majority of the members of the board. The term of a director or trustee shall be not less than 1 year nor more than 3 years, and shall be specified in the corporation's bylaws.

(2) The directors or trustees of a domestic corporation shall at all times include subscriber representatives.

(3) A majority of the board of directors or trustees shall at all times consist of members other than employees and officers of the corporation, or of any affiliate or subsidiary of the corporation.

(4) Not less than one-third of the members of the board of directors or trustees shall be residents of the District of Columbia.

(5) The articles of incorporation or bylaws of a domestic corporation shall state the number of directors or trustees necessary to constitute a quorum for conducting business at its meetings and the number of directors' or trustees' votes necessary to effect action on any matter presented for a vote of the board of directors or trustees. In regard to any matter involving conversion to a mutual or stock insurance company, or merger, consolidation, or other form of reorganization of the corporation, the affirmative vote of at least 80% of all directors or trustees shall be required to effect action by the board.

(Apr. 9, 1997, D.C. Law 11-245, § 19, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4718. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For 3501.

§ 31-3519. Reports to directors and trustees.

The officers or other management of a corporation issued a certificate of authority under this chapter shall report to its board of directors or trustees, no less often than quarterly, regarding any and all transactions or events that

have, or are likely to have, a material impact on the operations or financial condition of the corporation.

(Apr. 9, 1997, D.C. Law 11-245, § 20, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4719. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For

3501.

§ 31-3520. Oversight role and fiduciary obligation of directors, officers, and employees.

(a) The Mayor shall promulgate regulations establishing the oversight role and fiduciary obligation of each member of the board of directors or trustees of a corporation issued a certificate of authority under this chapter. Such regulations shall require the corporation to adopt a code of conduct and compliance program for all board members, officers and employees of the corporation.

(b) A corporation issued a certificate of authority under this chapter shall file with the Mayor annually, on or before June 1, a copy of its bylaws which shall require the corporation's board of directors or trustees to adopt policies consistent with the provisions of the code of conduct and compliance program regulations promulgated by the Mayor. Any amendments to the bylaws shall be filed with the Mayor by the corporation within 30 days of adoption by the board.

(Apr. 9, 1997, D.C. Law 11-245, § 21, 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4720. legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 11-245. — For

3501.

§ 31-3521. Sanctions for violations.

(a) If the directors or trustees of a corporation issued a certificate of authority under this chapter knowingly violate, or knowingly permit any of the officers, employees, or agents of the corporation to violate, any provision of this chapter, any other provision of law made applicable to the corporation by this chapter, or any regulation promulgated under this chapter or such other provisions of law, the certificate of authority granted to the corporation may be suspended or revoked upon a determination of such violation by the Mayor.

(b) Forfeiture of monetary gain; civil money penalties.

(1) The Mayor may require a corporation issued a certificate of authority under this chapter, and any director, trustee, officer, employee, or agent of such a corporation, that the Mayor finds has willfully violated any provision of this chapter, any other provision of law made applicable to the corporation by this chapter, or any regulations promulgated under this chapter or such other provision of law to forfeit any monetary gain derived thereby to the Treasurer of the District of Columbia or to any person who has suffered financial injury or damage as a result of the violation. Upon a determination of such violation by the Mayor, the Mayor also may impose a civil penalty against a corporation

in an amount not to exceed \$25,000 for each violation, and as to an individual an amount not to exceed \$5,000 for each type of violation, not to exceed \$25,000 in total for each type of violation.

(2) For the purposes of this section, the terms “violate” and “violation” denote any action, alone or with another or others, that involves causation, participation in, counseling, aiding, or abetting.

(3) A person or organization against whom a forfeiture or penalty has been imposed under this section may, within 30 days after service of written notice thereof by hand delivery or mail, make a written request for a hearing on such action by delivering the request to the Department of Insurance, Securities, and Banking. The hearing shall commence in not fewer than 10 days nor more than 30 days from the date on which the request for a hearing is received by the Department of Insurance, Securities, and Banking. The hearing and its disposition shall be governed by the rules for contested cases set forth in Title 26 (Insurance) of the District of Columbia Municipal Regulations (26 DCMR).

(4) The resignation, separation, or termination of a director, trustee, officer, employee, or agent (including a separation caused by the liquidation of a corporation issued a certificate of authority under this chapter) shall not affect the jurisdiction and authority of the Mayor to issue any notice and proceed under this subsection against any such individual, if the notice is served before the end of the 3-year period beginning on the date on which the individual ceased to be a director, trustee, officer, employee, or agent.

(c) Whenever the Mayor determines that a corporation issued a certificate of authority under this chapter, or that a director, trustee, officer, employee, or agent of such a corporation has committed or is about to commit a violation of this chapter or of any rule, regulation, or order issued hereunder, the Mayor may issue an order directing such corporation or individual to cease and desist from violating or continuing to violate this chapter or any such rule, regulation, or order, subject to the notice, hearing, and other procedural requirements in subsection (b) of this section.

(d) The foregoing penalties and remedies shall be in addition to, and not in lieu of, any other penalty which may be imposed pursuant to any other provision of law which this chapter makes applicable to a corporation and its officers, directors, employees, and agents. This section shall not be construed to prevent any person financially damaged by a director, trustee, officer, employee, or agent of a corporation from bringing a separate cause of action in a court of competent jurisdiction.

(e) Whenever the Mayor determines that a corporation issued a certificate of authority under this chapter, or that a director, trustee, officer, employee, or agent of such a corporation, has willfully violated this chapter, the Mayor shall report such violation to the Corporation Counsel of the District of Columbia. Willful violations of this chapter shall be deemed misdemeanors, except where other provisions of this chapter or other provisions of law made applicable by this chapter provide for greater criminal liability. Prosecutions authorized by this section shall be upon information filed in the Superior Court of the District of Columbia by the Corporation Counsel or any of his or her assistants. Any

corporation convicted of a willful violation of this chapter shall be fined in an amount not to exceed \$50,000 for each violation. In addition to any fines or punishments imposed for violations of any other laws, any individual convicted of a willful violation of this chapter shall be fined in an amount not to exceed \$5,000 for each violation; or, if such violation involves the deliberate perpetration of a fraud upon the corporation, its subscribers, or the Mayor, imprisoned for not more than 1 year, or both.

(Apr. 9, 1997, D.C. Law 11-245, § 22, 44 DCR 1158; June 11, 2004, D.C. Law 15-166, § 4(u)(4), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4721.

Effect of amendments. — D.C. Law 15-166, in par. (3) of subsec. (b), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation” both times it appears.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(u)(4) of

Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-3522. Appeals.

If, within the time for approval, the Mayor sends notice of disapproval of the proposed form of any subscriber contract, of proposed contract rates, or of any management contract or service agreement required by this chapter to be approved by the Mayor, the affected corporation may contest the Mayor’s decision. Any action to contest the Mayor’s decision shall be initiated within 30 days from the date on which the notice of decision is served on the corporation by delivering a written request for a hearing to the Department of Insurance, Securities, and Banking. The hearing shall commence in not fewer than 10 days nor more than 30 days from the date on which the action to contest the Mayor’s decision is received by the Department of Insurance, Securities, and Banking. The hearing and its disposition shall be governed by the procedures for contested cases in Chapter 1 of Title 26 (Insurance) of the District of Columbia Municipal Regulations (26 DCMR chapter 1).

(Apr. 9, 1997, D.C. Law 11-245, § 23, 44 DCR 1158; June 11, 2004, D.C. Law 15-166, § 4(u)(5), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-4722.

Effect of amendments. — D.C. Law 15-166 substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation” both times it appears.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(u)(5) of

Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-3523. General transition provisions.

(a) In his or her sole discretion, the Mayor may provide, upon application and for good cause shown by a corporation in existence and operating in the

District of Columbia on April 9, 1997, for a reasonable period of time for such corporation to comply with any requirement of this chapter.

(b) Notwithstanding any provisions to the contrary in Chapter 7 of this title, or this chapter, a transaction ongoing as of April 9, 1997, which would otherwise be subject to the notice requirements of § 31-706(a), shall be filed with the Mayor for approval no later than 90 days after April 9, 1997, only if the transaction involves more than 3% of the amount of admitted assets or more than 20% of the amount of surplus of the corporation as of the 31st day of the previous December, whichever amount is less. Failure of the Mayor to act within 60 days after such a filing shall constitute approval of the transaction. The Mayor shall not disapprove a transaction ongoing as of April 9, 1997, if the transaction was lawful when begun. Extension or renewal of a transaction ongoing as of April 9, 1997, shall be subject to the notice and other requirements of the Holding Company Systems Act of 1993, and shall not be renewed or extended except upon terms approved by the Mayor.

(Apr. 9, 1997, D.C. Law 11-245, § 24 44 DCR 1158.)

Prior Codifications. — 1981 Ed., § 35-4723.

Legislative history of Law 11-245. — For legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

References in text. — The “Holding Company Systems Act of 1993”, referred to in (b), is D.C. Law 10-44, which is codified primarily as § 31-701 et seq.

§ 31-3523.01. Regulatory authority.

Nothing in this chapter shall be construed to diminish the authority of the Council to regulate the affairs of Group Hospitalization and Medical Services, Inc.

(Apr. 9, 1997, D.C. Law 11-245, § 24a, as added Mar. 25, 2009, D.C. Law 17-369, § 2(i), 56 DCR 1346.)

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

§ 31-3524. Rules and regulations.

The Mayor, in accordance with subchapter I of Chapter 5 of Title 2, shall issue rules to implement the provisions of this chapter.

(Apr. 9, 1997, D.C. Law 11-245, § 25, 44 DCR 1158; Mar. 25, 2009, D.C. Law 17-369, § 2(j), 56 DCR 1346.)

Prior Codifications. — 1981 Ed., § 35-4724.

Effect of amendments. — D.C. Law 17-369 substituted “shall” for “may”.

Legislative history of Law 11-245. — For

legislative history of D.C. Law 11-245, see Historical and Statutory Notes following § 31-3501.

Legislative history of Law 17-369. — For Law 17-369, see notes following § 31-3501.

CHAPTER 36. LONG-TERM CARE INSURANCE.

Sec.	Sec.
31-3601. Definitions.	31-3608. Monthly reports.
31-3602. Scope.	31-3609. Incontestability period.
31-3603. Long-term insurance; who may issue.	31-3609.01. Denial of claims.
31-3604. Group policies issued in other states.	31-3610. Nonforfeiture benefits.
31-3605. Standards for long-term care insurance.	31-3611. Rules and regulations.
31-3606. Disclosure.	31-3612. Penalties.
31-3607. Minimum number of members for associations.	

§ 31-3601. Definitions.

For the purposes of this chapter, the term:

(1) "Applicant" means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in the District of Columbia.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in the District of Columbia and issued to one of the following groups:

(A) One or more employers or labor organizations, a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations;

(B) Any professional, trade, or occupational association for its members, former or retired members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance;

(C) An association, trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations;

(D) Any other group; provided that, the Commissioner finds the following:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relations to the premiums charged.

(5)(A) “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. “Long-term care insurance” includes group and individual annuities and life insurance policies or riders which provide directly, or which supplement, long-term care insurance. “Long-term care insurance” also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity as well as qualified long-term care insurance contracts.

(B) “Long-term care insurance” shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, “long-term care insurance” shall not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and which provide the option of lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(6) “Nonforfeiture benefit” means a benefit provided to a policyholder in the event of nonpayment of a premium due.

(7) “Policy” means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in the District of Columbia by an insurer; fraternal benefits society; nonprofit health, hospital, or medical service corporation; prepaid health plan, health maintenance organization, or any similar organization.

(8)(A) “Qualified long-term care insurance contract” means an individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 259; 26 U.S.C. § 7702B(b)), and the following:

(i) The only insurance protection provided under the contract is coverage of qualified long-term care services; provided, that a contract shall not fail to satisfy the requirements of this sub-subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(ii) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses incurred for services or items are reimbursable under Title XVIII of the Social Security Act, approved July 30, 1965 (79 Stat. 291; 42 U.S.C. § 1395 et seq.), or would be so reimbursable but for the application of a deductible or coinsurance amount; provided, that the requirements of this sub-subparagraph shall not apply to expenses that are reimbursable under Title XVIII of the Social Security Act, approved July 30,

1965 (79 Stat. 291; 42 U.S.C. § 1395 et seq.), only as a secondary payor; provided further, that a contract shall not fail to satisfy the requirements of this sub-subparagraph by reason of payments being made on a per diem or other periodic basis without regard to expenses incurred during the period to which the payments relate;

(iii) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 259; 26 U.S.C. § 7702B(b)(1)(C));

(iv) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided by sub-subparagraph (v) of this subparagraph;

(v) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits; provided, that a refund in the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(vi) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 259; 26 U.S.C. § 7702B(g)).

(B) "Qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies requirements of section 7702B(b) and (e) of the Internal Revenue Code of 1986, approved August 21, 1996 (110 Stat. 259; 26 U.S.C. § 7702B(c) and (e)).

(May 23, 2000, D.C. Law 13-121, § 2, 47 DCR 2038; Oct. 1, 2002, D.C. Law 14-190, § 502(a), 49 DCR 6968; June 11, 2004, D.C. Law 15-166, § 4(v), 51 DCR 2817.)

Effect of amendments. — D.C. Law 14-190, in par. (5)(A), substituted "loss of functional capacity as well as qualified long-term care insurance contracts" for "loss of functional capacity"; and added par. (8).

D.C. Law 15-166, in par. (3), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of the District of Columbia Department of Insurance and Securities Regulation".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(a) of Long-Term Care Insurance Temporary Amendment Act of 2000 (D.C. Law 13-147, July 18, 2000, law notification 47 DCR 6097).

Emergency legislation. — For temporary (90-day) amendment of section, see § 2(a) of the Long-Term Care Insurance Emergency Amendment Act of 2000 (D.C. Act 13-312, April 7, 2000, 47 DCR 2738).

For temporary (90-day) amendment of section, see § 2(a) of the Long-Term Care Insurance Congressional Review Emergency Amend-

ment Act of 2000 (D.C. Act 13-370, July 10, 2000, 47 DCR 5838).

For temporary (90 day) amendment of section, see § 502(a) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

For temporary (90 day) amendment of section, see § 4(v) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 13-121. — Law 13-121, the "Long-Term Care Insurance Act of 2000," was introduced in Council and assigned Bill No. 13-246, which was referred to the Committee on Human Services. The Bill was adopted on first and second readings on January 4, 2000, and February 1, 2000, respectively. Signed by the Mayor on February 23, 2000, it was assigned Act No. 13-287 and transmitted to both Houses of Congress for its review. D.C. Law 13-121 became effective on May 23, 2000.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Short title. — Short title of title V of Law 14-190: Section 501 of D.C. Law 14-190 pro-

vided that title V of the act may be cited as the Long-Term Insurance Conformity Amendment Act of 2002.

§ 31-3602. Scope.

(a) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance delivered or issued for delivery in the District of Columbia shall comply with the provisions of this chapter.

(b) This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this chapter; except that, this chapter shall supersede laws and regulations designed and intended to apply to Medicare supplement insurance policies.

(c) The requirements of this chapter shall apply to policies delivered or issued for delivery in the District of Columbia on or after May 23, 2000.

(May 23, 2000, D.C. Law 13-121, § 3, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3603. Long-term insurance; who may issue.

Long-term care insurance may be issued by insurers, fraternal benefits societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, and health maintenance organizations, and any similar organization to the extent they are otherwise authorized to issue life or health insurance. Any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this chapter.

(May 23, 2000, D.C. Law 13-121, § 4, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3604. Group policies issued in other states.

No group long-term care insurance coverage may be offered to a resident of the District of Columbia under a group policy issued in another state to a group described in § 31-3601(4)(D), unless the District of Columbia, or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the District of Columbia has made a determination that such requirements have been met.

(May 23, 2000, D.C. Law 13-121, § 5, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3605. Standards for long-term care insurance.

(a) No long-term care insurance policy shall:

(1) Be cancelled, not renewed, or otherwise terminated on the grounds of the age or deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form of coverage within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(b)(1) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as described in § 31-3601(4)(A), shall contain a definition of “preexisting condition” which is more restrictive than the following definition: “A condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person.”

(2) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as described in § 31-3601(4)(A), may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (1) and (2) of this subsection as to specific group categories in specific policy forms if the Commissioner finds that the extension is in the best interest of the public.

(4) Nothing in this chapter shall be construed to prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection.

(c)(1) No long-term care insurance policy may be delivered or issued for delivery in the District if such policy:

(A) Conditions eligibility for any benefits on a prior hospitalization requirement;

(B) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(C) Conditions eligibility for any benefits other than waiver of pre-

mium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2)(A) A long-term care insurance policy containing post-confinement post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(B) A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(d)(1) Applicants for long-term care insurance shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(2) Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in § 31-3601(4)(A), the applicant is not satisfied for any reason.

(3) If an application for a long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fees submitted by the applicant within 30 days of the denial.

(May 23, 2000, D.C. Law 13-121, § 6, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3606. Disclosure.

(a)(1) An outline of coverage, written at a fifth grade reading level, shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(2) When an agent solicits individuals to purchase long-term care insurance, the agency must deliver the outline of coverage before the presenting of an application or enrollment form to the person being solicited to make a purchase.

(3) In the case of direct response solicitations, the outline of coverage must be presented no later than when any application or enrollment form is presented.

(b) The outline of coverage shall include the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement of the terms under which the policy or certificate, or both,

may be contained in force or discontinued, including any reservation in the policy of a right to change premium (continuation or conversion provisions of group coverage shall be specifically described);

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) A description of the relationship of cost of care and benefits; and contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a long-term care insurance contract.

(6) A brief description of the relationship of cost of care and benefits; and

(7) If the policy or certificate is intended to be a qualified long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

(c) In the case of a policy issued to a group described in § 31-3601(4)(D), an outline of coverage shall not be required to be delivered; provided that, the information described in subsection (e) of this section is contained in other material relating to enrollment. Upon request, these other materials shall be made available to the Commissioner.

(d) A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in the District of Columbia shall include the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions.

(e) At the time of policy, deliver, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary either upon the applicant's request, or the time of policy delivery, whichever occurs later. In addition to complying with all other applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefits interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, for each covered person, if any:

(3) Any exclusions, reductions, and limitations on benefits of long-term care; and

(4) If applicable to the policy type, the following:

(A) A disclosure of the effects or exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(f) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

(May 23, 2000, D.C. Law 13-121, § 7, 47 DCR 2038; Oct. 1, 2002, D.C. Law 14-190, § 502(b), 49 DCR 6968; Mar. 13, 2004, D.C. Law 15-105, § 67, 51 DCR 881; Apr. 13, 2005, D.C. Law 15-354, § 44, 52 DCR 2638.)

Effect of amendments. — D.C. Law 14-190, in subsec. (b)(7), substituted “qualified long-term care insurance contract” for “long-term insurance care contract” in two places; and added subsec. (f).

D.C. Law 15-105, in subsecs. (b) and (f), validated previously made technical corrections.

D.C. Law 15-354, in subsec. (b)(7), validated a previously made technical correction.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(b) of Long-Term Care Insurance Temporary Amendment Act of 2000 (D.C. Law 13-147, July 18, 2000, law notification 47 DCR 6097).

Emergency legislation. — For temporary (90-day) amendment of section, see § 2(b) of the Long-Term Care Insurance Emergency

Amendment Act of 2000 (D.C. Act 13-312, April 7, 2000, 47 DCR 2738).

For temporary (90-day) amendment of section, see § 2(b) of the Long-Term Care Insurance Congressional Review Emergency Amendment Act of 2000 (D.C. Act 13-370, July 10, 2000, 47 DCR 5838).

For temporary (90 day) amendment of section, see § 502(b) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 15-105. — For Law 15-105, see notes following § 31-2402.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

§ 31-3607. Minimum number of members for associations.

(a) Prior to advertising, marketing, or offering a group long-term care insurance policy within the District of Columbia, an association or associations, or an insurer of the association or associations, shall file evidence with the Commissioner that the association, or associations has:

- (1) At the outset, a minimum of 100 members;
- (2) Been organized and maintained in good faith for purposes other than that of obtaining insurance;
- (3) Been in active existence for at least one year; and
- (4) A constitution and bylaws which provide the following:
 - (A) That the association or associations hold regular meetings not less than annually to further the purposes of the members;
 - (B) That, except for credit unions, the association or associations collect dues or solicit contributions from members; and
 - (C) That the members have voting privileges and representation on the governing board and committees.

(b) Thirty days after the filing required by subsection (a) of this section, the association or associations shall be deemed to have satisfied the organizational requirements of subsection (a) of this section unless the Commissioner make a finding that the association, or associations, does not satisfy the organizational requirements.

(May 23, 2000, D.C. Law 13-121, § 8, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3608. Monthly reports.

Any time a long-term care benefit which is funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The monthly report shall include the following:

- (1) Any long-term care benefits paid out during the month;
- (2) An explanation of any changes in the policy (e.g., death benefits or cash values due to long-term care benefits being paid out); and
- (3) The amount of long-term care benefits existing or remaining.

(May 23, 2000, D.C. Law 13-121, § 9, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3609. Incontestability period.

(a) If a policy or certificate has been in force for less than 6 months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(b) If a policy or certificate has been in force for at least 6 months, but less than 2 years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(c) After a policy or certificate has been in force for 2 years, it shall not be contestable upon the grounds of misrepresentations alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d)(1) No long-term care insurance policy or certificate may be field unless based on medical or health status.

(2) For purposes of this subsection, the term "field issued" means a policy or certificate issued by an agent or third party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under a long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(f)(1) In the event of the death of the insured, this section shall not apply to the remaining death benefits of a life insurance policy that accelerates benefits for long term care; except that, in the event of death of the insured, the remaining death benefits under these policies shall be governed by § 31-4803.

(May 23, 2000, D.C. Law 13-121, § 10, 47 DCR 2038.)

Temporary Amendment of Section. — see § 2(c) of Long-Term Care Insurance Temporary Amendment Act of 2000 (D.C. Law 13-

147, July 18, 2000, law notification 47 DCR 6097).

Emergency legislation. — For temporary (90-day) addition of § 35-4909.1 1981 Ed., see § 2(c) of the Long-Term Care Insurance Emergency Amendment Act of 2000 (D.C. Act 13-312, April 7, 2000, 47 DCR 2738).

For temporary (90-day) addition of § 35-4909.1 1981 Ed., see § 2(c) of the Long-Term

Care Insurance Congressional Review Emergency Amendment Act of 2000 (D.C. Act 13-370, July 10, 2000, 47 DCR 5838).

For temporary (90 day) addition of § 31-3609.01, see § 502(c) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3609.01. Denial of claims.

If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

- (1) Provide a written explanation of the reasons for the denial; and
- (2) Make available all information directly related to the denial.

(May 23, 2000, D.C. Law 13-121, § 10a, as added Oct. 1, 2002, D.C. Law 14-190, § 502(c), 49 DCR 6968.)

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

§ 31-3610. Nonforfeiture benefits.

(a) Except as provided in subsection (b) of this section, a long-term care insurance policy may not be delivered or issued for delivery in the District of Columbia unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(b) When a group long-term care insurance policy is issued, the offer required in subsection (a) of this section shall be made to the group policyholder. If, however, the policy is issued as a group long-term care insurance as described in § 31-3601(4)(D), other than a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(c) The Commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding a contingent benefit upon lapse, including a determination of the specified period of time during a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (a) of this section.

(May 23, 2000, D.C. Law 13-121, § 11, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3611. Rules and regulations.

The Commissioner may issue rules to implement any provisions of this chapter. The rules may include:

(1) Requirements for any disclosure made under this chapter, including the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents and preexisting conditions, termination of coverage, continuation or conversion of coverage, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions;

(2) Loss ratio standards specifically applicable to long-term care insurance policies;

(3) A standard format, which may include a description of the style, arrangement, overall appearance, and the content of an outline of coverage; and

(4) Minimum standards for making and reporting practices for long-term care insurance.

(May 23, 2000, D.C. Law 13-121, § 12, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

§ 31-3612. Penalties.

In addition to any other penalties provided by law, if, after a judicial proceeding or an administrative proceeding conducted in accordance with subchapter I of Chapter 5 of Title 2, an insurer or any agent is found to have violated any requirements of this chapter, that insurer or agent shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

(May 23, 2000, D.C. Law 13-121, § 13, 47 DCR 2038.)

Legislative history of Law 13-121. — For Law 13-121, see notes following § 31-3601.

CHAPTER 37. MEDICARE SUPPLEMENT INSURANCE.

Subchapter I. General

Sec.

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31-3751 to 31-3760. [Repealed].

Subchapter I. General.

§ 31-3701. Definitions.

For the purposes of this subchapter, the term:

(1) "Applicant" means:

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(B) In the case of a group Medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means any certificate delivered or issued for delivery in the District of Columbia under a group Medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the insurer.

(4) "Issuer" means an insurance company, a fraternal benefit association, a health care service plan, a health maintenance organization, and any other entity delivering or issuing for delivery in the District of Columbia Medicare supplement policies or certificates. The term "issuer" includes Group Hospitalization and Medical Services, Incorporated.

(5) "Medicare" means the health insurance program established pursuant to the Health Insurance for the Aged Act (42 U.S.C. § 303 et seq.).

(6) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under § 1876 of the Social Security Act (42 U.S.C. § 1395mm), or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(7) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(Oct. 1, 1992, D.C. Law 9-170, § 2, 39 DCR 5825; Apr. 9, 1997, D.C. Law 11-202, § 2(a), 43 DCR 6054; Mar. 24, 1998, D.C. Law 12-81, § 35(a), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-2611.

Temporary Addition of Section. — For temporary (225 day) addition of §§ 35-2611 through 35-2620 comprising Chapter 26 of Title 35 1981 Ed., see §§ 2 to 11 of Medicare Supplement Insurance Minimum Standard Temporary Act of 1992 (D.C. Law 9-133, July 22, 1992, law notification 39 DCR 5814).

Emergency legislation. — For temporary amendment of section, see § 2(a) of the Medicare Supplement Insurance Minimum Standards Emergency Amendment Act of 1996 (D.C. Act 11-244, April 11, 1996, 43 DCR 2119), § 2(a) of the Medicare Supplement Insurance Minimum Standards Legislative Review Emergency Amendment Act of 1996 (D.C. Act 11-396, October 9, 1996, 43 DCR 5684), § 2(a) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-416, October 28, 1996, 43 DCR 6078), § 2(a) of the Medicare Supplement Insurance Minimum Standards Second Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-474, December 30, 1996, 44 DCR 198), and see § 2(a) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1997 (D.C. Act 12-49, March 31, 1997, 44 DCR 2112).

Legislative history of Law 9-170. — Law 9-170, the “Medicare Supplement Insurance Minimum Standards Act of 1992,” was introduced in Council and assigned Bill No. 9-459, which was referred to the Committee on Human Services and reassigned to the Committee on Consumer and Regulatory Affairs. The Bill

was adopted on first and second readings on June 2, 1992, and July 7, 1992, respectively. Signed by the Mayor on July 23, 1992, it was assigned Act No. 9-268 and transmitted to both Houses of Congress for its review. D.C. Law 9-170 became effective on October 1, 1992.

Legislative history of Law 11-202. — Law 11-202, the “Medical Supplement Insurance Minimum Standards Amendment Act of 1996,” was introduced in Council and assigned Bill No. 11-627. The Bill was adopted on first and second readings on July 3, 1996, and July 17, 1996, respectively. Signed by the Mayor on August 5, 1996, it was assigned Act No. 11-367 and transmitted to both Houses of Congress for its review. D.C. Law 11-202 became effective on April 9, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Delegation of Authority. — Delegation of authority under D.C. Act 9-199, the Medicare Supplement Insurance Minimum Standards Emergency Act of 1992, see Mayor’s Order 92-92, July 20, 1992.

Delegation of authority under D.C. Law 9-170, the Medicare Supplement Insurance Standards Act of 1992, see Mayor’s Order 93-60, May 12, 1993.

§ 31-3702. Applicability and scope.

(a) Except as otherwise specifically provided, this subchapter shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in the District of Columbia on or after October 1, 1992; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in the District of Columbia.

(b) This subchapter shall not apply to a policy for 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(c) Except as otherwise specifically provided in § 31-3706(d) [sic], the provisions of this subchapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies are not marketed or held to be Medicare supplement policies or benefit plans.

(Oct. 1, 1992, D.C. Law 9-170, § 3, 39 DCR 5825; Apr. 9, 1997, D.C. Law 11-202, §§ 2(b)-(c), 43 DCR 6054.)

Prior Codifications. — 1981 Ed., § 35-2612.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Emergency legislation. — For temporary amendment of section, see § 2(b) and (c) of the Medicare Supplement Insurance Minimum Standards Emergency Amendment Act of 1996 (D.C. Act 11-244, April 11, 1996, 43 DCR 2119), § 2(b) and (c) of the Medicare Supplement Insurance Minimum Standards Legislative Review Emergency Amendment Act of 1996 (D.C. Act 11-396, October 9, 1996, 43 DCR 5684), § 2(b) and (c) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-416, October 28, 1996, 43 DCR 6078), § 2(b) and (c) of the Medicare Supplement Insurance Minimum Standards Second

Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-474, December 30, 1996, 44 DCR 198), and see § 2(b) and (c) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1997 (D.C. Act 12-49, March 31, 1997, 44 DCR 2112).

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 11-202. — For legislative history of D.C. Law 11-202, see Historical and Statutory Notes following § 31-3701.

§ 31-3703. Standards for policy provisions and authority to promulgate regulations.

(a) No Medicare supplement policy or certificate in force in the District of Columbia shall contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of the District of Columbia, a Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(c) The Mayor shall issue reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards shall be in addition to and in accordance with applicable laws of the District of Columbia. No requirement of District of Columbia law relating to minimum required policy benefits, other than the minimum standards contained in this subchapter, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

- (1) Terms of renewability;
- (2) Initial and subsequent conditions of eligibility;
- (3) Nonduplication of coverage;
- (4) Probationary periods;
- (5) Benefit limitations, exceptions, and reductions;
- (6) Elimination periods;
- (7) Requirements for replacement;
- (8) Recurrent conditions; and
- (9) Definition of terms.

(d) The Mayor shall issue reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(e) The Mayor may issue reasonable regulations necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare select policies and certificates.

(f) The Mayor may issue reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute, which, in the opinion of the Mayor, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

(Oct. 1, 1992, D.C. Law 9-170, § 4, 39 DCR 5825; May 23, 2000, D.C. Law 13-122, § 2, 47 DCR 2048.)

Prior Codifications. — 1981 Ed., § 35-2613.

Effect of amendments. — D.C. Law 13-122 in subsec. (b), in the first sentence, substituted “exclude” for “include”.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 13-122. — Law 13-122, the “Medicare Supplement Insurance Minimum Standards Amendment Act of 2000,” was introduced in Council and assigned Bill No. 13-258, which was referred to the Committee on Human Services. The Bill was adopted on first and second readings on January 4, 2000, and February 1, 2000, respectively. Signed by the Mayor on February 23, 2000, it was assigned Act No. 13-288 and transmitted to both Houses of Congress for its review. D.C. Law 13-122 became effective on May 23, 2000.

§ 31-3704. Loss ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The Mayor shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(Oct. 1, 1992, D.C. Law 9-170, § 5, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., § 35-2614.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

§ 31-3705. Disclosure standards.

(a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in the District of Columbia unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Mayor shall prescribe the format and content of the outline of coverage required by subsection (c) of this section. For purposes of this section, the term “format” means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums, and disclosure of the existence of any automatic renewal premium increases based on the policyholder’s age; and

(3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The Mayor may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer’s ability to select the most appropriate coverage and improve the buyer’s understanding of Medicare. Except in the case of the direct response insurance policies, the Mayor may require by regulation that the informational brochure be provided to any prospective insured eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the Mayor may require by regulation that the prescribed brochure be provided upon request to any prospective insured eligible for Medicare, but in no event later than the time of policy delivery.

(d) The Mayor may issue regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for Medicare, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

(3) Repealed.

(4) Repealed.

(e) The Mayor may issue reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident

and sickness policies, subscriber contracts, or certificates by persons eligible for Medicare.

(Oct. 1, 1992, D.C. Law 9-170, § 6, 39 DCR 5825; Apr. 9, 1997, D.C. Law 11-202, §§ 2(d)-(f), 43 DCR 6054; Mar. 24, 1998, D.C. Law 12-81, § 35(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-2615.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Emergency legislation. — For temporary amendment of section, see § 2(d) through (f) of the Medicare Supplement Insurance Minimum Standards Emergency Amendment Act of 1996 (D.C. Act 11-244, April 11, 1996, 43 DCR 2119), § 2(d) through (f) of the Medicare Supplement Insurance Minimum Standards Legislative Review Emergency Amendment Act of 1996 (D.C. Act 11-396, October 9, 1996, 43 DCR 5684), § 2(d) through (f) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-416, October 28, 1996, 43 DCR 6078), § 2(d) through (f) of the Medicare Supplement Insurance Minimum Standards Second Congressional Review Emergency Amendment Act of 1996 (D.C. Act 11-474, December

30, 1996, 44 DCR 198), and see § 2(d) through (f) of the Medicare Supplement Insurance Minimum Standards Congressional Review Emergency Amendment Act of 1997 (D.C. Act 12-49, March 31, 1997, 44 DCR 2112).

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 11-202. — For legislative history of D.C. Law 11-202, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-3701.

§ 31-3706. Filing requirements; master policy and certificate.

(a) Except as provided in subsection (b) of this section, any insurer who provides group Medicare supplement insurance benefits to a resident of the District shall file the master policy and certificate, as provided by rule issued pursuant to § 31-3710.

(b) An insurer shall not be required to file the master policy and certificate within the 30-day period following the date that the insurance is provided if the policy is a master policy issued for delivery outside the District.

(Oct. 1, 1992, D.C. Law 9-170, § 7, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., § 35-2616.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

§ 31-3707. Notice of free examination.

Medicare supplement policies and certificates shall have a notice prominently printed on the 1st page of the policy or certificate, or attached thereto, stating in substance that the applicant shall have the right to return the policy

or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(Oct. 1, 1992, D.C. Law 9-170, § 8, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., § 35-2617.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

§ 31-3708. Filing requirements for advertising.

(a) The Mayor shall establish, by rule, standards for advertising Medicare supplement insurance and benefits in the District.

(b) Each insurer, health care service plan, or other entity that provides Medicare supplement insurance or benefits in the District shall provide the Mayor, for review, a copy of any Medicare supplement advertisement intended for use in the District.

(Oct. 1, 1992, D.C. Law 9-170, § 9, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., § 35-2618.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

§ 31-3709. Remedies.

In addition to any other applicable penalty for a violation of the insurance laws of the District, the Mayor may require an insurer who violates this subchapter, or rules issued pursuant to this subchapter, to cease marketing in the District any Medicare supplement policy or certificate that is related directly or indirectly to a violation, or may require the issuer to take any actions necessary to comply with the provisions of this subchapter, or both.

(Oct. 1, 1992, D.C. Law 9-170, § 10, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., § 35-2619.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see His-

torical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

§ 31-3710. Rules.

(a) The Mayor shall issue proposed rules to implement the provisions of this subchapter within 180 days of October 1, 1992. The proposed rules shall be submitted to the Council for a 45-day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution within this 45-day period, the proposed rules shall be deemed approved. Nothing in this section shall affect any requirements imposed upon the Mayor by subchapter I of Chapter 5 of Title 2.

(b) The Mayor may issue emergency rules without prior Council approval, which shall be effective for not more than 120 days.

(Oct. 1, 1992, D.C. Law 9-170, § 11, 39 DCR 5825.)

Section references. — This section is referred to in § 31-3706.

Prior Codifications. — 1981 Ed., § 35-2620.

Temporary Addition of Section. — See Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-133. — For legislative history of D.C. Law 9-133, see Historical and Statutory Notes following § 31-3701.

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

Resolutions. — Resolution 16-394, Medicare Supplement Insurance Minimum Standards Approval Resolution of 2005, was approved effective November 26, 2005.

Resolution 16-788, the “Medicare Supplement Insurance Minimum Standards Approval Resolution of 2006”, was approved effective August 11, 2006.

Resolution 18-298, the “Medicare Supplement Insurance Minimum Standards Approval Resolution of 2009”, was approved effective November 3, 2009.

Subchapter II. Repealed Provisions.

§§ 31-3751 to 31-3760. Definitions; applicability and scope; standards for policy provisions; filing requirements; master policy and certificate; loss ratio standards; disclosure standards; outline of coverage; notice of free examination; filing requirements for advertising; remedies; rules. [Repealed].

Repealed.

(Oct. 1, 1992, D.C. Law 9-170, § 12, 39 DCR 5825.)

Prior Codifications. — 1981 Ed., §§ 35-2601 to 35-2610.

Temporary Amendment of Section. — For temporary (225 day) repeal of §§ 35-2601 to 35-2610 1981 Ed., see § 2 of Medicare Supplement Insurance Minimum Standard Tempo-

rary Act of 1992 (D.C. Law 9-133, July 22, 1992, law notification 39 DCR 5814).

Legislative history of Law 9-170. — For legislative history of D.C. Law 9-170, see Historical and Statutory Notes following § 31-3701.

CHAPTER 38. NEWBORN HEALTH INSURANCE.

Sec.

31-3801. Payable benefits.

31-3802. [Repealed].

31-3802.01. Inpatient postpartum treatment;
at-home post-delivery care.

Sec.

31-3803. Notification of birth and payment of
premiums or fees.

31-3804. Applicability of chapter.

31-3805. Exclusions.

§ 31-3801. Payable benefits.

All individual and group health insurance policies providing coverage on an expense-incurred basis and individual and group service-or indemnity-type contracts issued by a nonprofit health service plan shall provide that health insurance benefits shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(Oct. 20, 1979, D.C. Law 3-33, § 2, 26 DCR 1116.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-1101.

1973 Ed., § 35-2001.

Legislative history of Law 3-33. — Law 3-33, the “Newborn Health Insurance Act of 1979,” was introduced in Council and assigned

Bill No. 3-12, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on July 17, 1979, and July 31, 1979, respectively. Signed by the Mayor on August 31, 1979, it was assigned Act No. 3-99 and transmitted to both Houses of Congress for its review.

§ 31-3802. Extent of coverage. [Repealed].

Repealed.

(Oct. 20, 1979, D.C. Law 3-33, § 3, 26 DCR 1116; May 21, 1992, D.C. Law 9-99, § 2(a), 39 DCR 2142; Apr. 13, 2005, D.C. Law 15-353, § 351, 52 DCR 2331.)

Prior Codifications. — 1981 Ed., § 35-1102.

1973 Ed., § 35-2002.

Temporary Repeal of Section For temporary (225 day) repeal of section, see § 306 of the Child and Youth, Safety and Health Omnibus Second Temporary Amendment Act of 2004 (D.C. Law 15-319, April 8, 2005, law notification 52 DCR 4708).

Emergency legislation. — For temporary (90 day) repeal of section, see § 306 of Child and Youth, Safety and Health Omnibus Emergency Amendment Act of 2004 (D.C. Act 15-630, November 30, 2004, 52 DCR 1143).

For temporary (90 day) repeal of section, see § 351 of Child and Youth, Safety and Health Omnibus Congressional Review Emergency Amendment Act of 2005 (D.C. Act 16-30, February 17, 2005, 52 DCR 2993).

Legislative history of Law 3-33. — For legislative history of D.C. Law 3-33, see Historical and Statutory Notes following § 31-3801.

Legislative history of Law 9-99. — For legislative history of D.C. Law 9-99, see Historical and Statutory Notes following § 31-3805.

Legislative history of Law 15-353. — Law 15-353, the “Child and Youth, Safety and Health Omnibus Amendment Act of 2004,” was introduced in Council and assigned Bill No. 15-607 which was referred to the Committees on Human Services, Finance and Revenue, and Education, Libraries and Recreation. The Bill was adopted on first and second readings on December 7, 2004, and December 21, 2004, respectively. Signed by the Mayor on January 19, 2005, it was assigned Act No. 15-759 and transmitted to both Houses of Congress for its review. D.C. Law 15-353 became effective on April 13, 2005.

§ 31-3802.01. Inpatient postpartum treatment; at-home post-delivery care.

(a) Except as provided in subsection (b) of this section, all individual and group health policies providing maternity and newborn care coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit health service plan, including policies issued by Group Hospitalization and Medical Services, Inc., shall provide coverage for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care ("Guidelines") prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services ("Standards") prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Caesarian delivery.

(b) A private review agent or health maintenance organization may authorize a shorter length of stay if the physician, in consultation with the mother, determines that the newborn and mother meet the criteria for medical stability in accordance with the Guidelines or Standards.

(c) In all cases of early discharge pursuant to subsection (b) of this section, the insurer shall provide coverage for post-delivery care within the minimum time periods established in subsection (a) of this section, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- (1) Parental education;
- (2) Assistance and training in breast or bottle feeding; and
- (3) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

(d) Upon notification of the pregnancy of the insured, the insurer shall:

- (1) Encourage and assist the insured, prior to the delivery date, to select and contact a primary care provider for the expected newborn prior to delivery; and,

- (2) Provide the insured prior to the delivery date with information on postpartum home visits for the mother and child that includes the names of providers that are available for postpartum home visits.

(e) No insurer may deselect, terminate the services of, require additional documentation from, require additional utilization review, reduce payments, or otherwise provide financial disincentives to any attending provider who orders care consistent with this chapter.

(f) Every insurer shall provide notice to policyholders regarding the coverage required under this chapter. The notice shall be in writing and shall be transmitted at the earliest of either the next mailing to the policyholder, the

yearly summary of benefits sent to the policyholder, or January 1 of the year following April 9, 1997.

(Oct. 20, 1979, D.C. Law 3-33, § 3a, as added Apr. 9, 1997, D.C. Law 11-241, § 3, 44 DCR 1125.)

Prior Codifications. — 1981 Ed., § 35-1102.1.

Legislative history of Law 11-241. — Law 11-241, the “Newborn Health Insurance Amendment Act of 1996,” was introduced in Council and assigned Bill No. 11-, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-501 and transmitted to both Houses of Congress for its review. D.C. Law 11-241 became effective on April 9, 1997.

Purpose of Law 11-241. — Section 2 of D.C. Law 11-241 provided:

“(a) The Council of the District of Columbia finds that:

“(1) Phenylketonuria (“PKU”) is a cause of severe mental retardation that can be prevented if diagnosed within the first 3 weeks of childbirth.

“(2) The District’s statutes and regulations direct the screening of newborn infants for

hereditary and congenital disorders in the hospital prior to discharge.

“(3) Hospital stays of less than 24 hours after childbirth typically result in unsatisfactory PKU specimens as a result of insufficient milk feedings.

“(4) Insurers, both indemnity and managed care plans, have implemented benefit plans covering no more than 24 hours of postpartum stay in a hospital, despite little or no scientific support for the efficacy of this policy for the general population.

“(5) The Guidelines for Perinatal Care, prepared by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, recommends a hospital stay of at least 48 hours after childbirth.

“(b) In the interest of maximizing the prevention of mental retardation from PKU and other hereditary and congenital disorders, the Council of the District of Columbia hereby establishes a policy to require all individual and group health insurance policies to provide coverage for a minimum hospital stay for a mother and child following the birth of a child.”

§ 31-3803. Notification of birth and payment of premiums or fees.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.

(Oct. 20, 1979, D.C. Law 3-33, § 4, 26 DCR 1116.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-1103.

1973 Ed., § 35-2003.

Legislative history of Law 3-33. — For legislative history of D.C. Law 3-33, see Historical and Statutory Notes following § 31-3801.

§ 31-3804. Applicability of chapter.

The requirements of this chapter shall apply:

(1) To all insurance policies and subscriber contracts delivered or issued for delivery in the District more than 120 days after October 20, 1979.

(2) To all such insurance policies and subscriber contracts renewed, amended or reissued after 120 days following October 20, 1979;

(3) To only children born more than 120 days after October 20, 1979;

(4) To all individual subscriber contracts and group certificates issued or delivered in the District of Columbia by Group Hospitalization and Medical Services, Inc.;

(5) To all for-profit as well as nonprofit indemnity type health insurers issuing or delivering individual indemnity type accident and sickness health insurance policies and group certificates in the District of Columbia; and

(6) To health insurance certificates, except those described in § 31-3802(2) [repealed], that are delivered within the District of Columbia from group health insurance policies which are sold outside of the District of Columbia.

(Oct. 20, 1979, D.C. Law 3-33, § 5, 26 DCR 1116; May 21, 1992, D.C. Law 9-99, § 2(b), 39 DCR 2142.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-1104.

1973 Ed., § 35-2004.

Legislative history of Law 3-33. — For

legislative history of D.C. Law 3-33, see Historical and Statutory Notes following § 31-3801.

Legislative history of Law 9-99. — For legislative history of D.C. Law 9-99, see Historical and Statutory Notes following § 31-3805.

§ 31-3805. Exclusions.

Specifically excluded from the coverage requirements of this chapter are Medicare Supplement insurance policies, accident only policies, dread disease policies, student accident policies, nursing home policies, and home health care policies.

(Oct. 20, 1979, D.C. Law 3-33, § 6, as added May 21, 1992, D.C. Law 9-99, § 2(c), 39 DCR 2142.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-1105.

Legislative history of Law 9-99. — Law 9-99, the "Well-Child Care Amendment Act of 1992," was introduced in Council and assigned Bill No. 9-81, which was referred to the Com-

mittee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on February 4, 1992, and March 3, 1992, respectively. Signed by the Mayor on March 23, 1992, it was assigned Act No. 9-171 and transmitted to both Houses of Congress for its review. D.C. Law 9-99 became effective on May 21, 1992.

CHAPTER 38A. WOMEN'S RIGHTS REGARDING CERTAIN HEALTH INSURANCE.

Sec.

31-3831. Definitions.

31-3832. Coverage for reconstructive surgery following mastectomies.

31-3833. Notice.

31-3834. Hormone replacement therapy coverage.

Sec.

31-3835. Prohibitions.

31-3836. Regulations.

31-3837. Applicability to group health plans.

§ 31-3831. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means Commissioner of the Department of Insurance and Securities Regulation.

(2) "District" means the District of Columbia.

(3) "Group health plan" means an employee welfare plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 829; 29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and includes items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(4) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and includes items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by a health insurer.

(5) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) "Individual health plan" means a plan offering health insurance coverage offered to individuals other than in connection with a group health plan.

(8) "Mastectomy" means the surgical removal of all or substantially all of a breast as a result of breast cancer.

(Apr. 3, 2001, D.C. Law 13-254, § 2, 48 DCR 723.)

Legislative history of Law 13-254. — Law 13-254, the "Woman's Health and Cancer Rights Federal Law Conformity Act of 2000," was introduced in Council and assigned Bill No. 13-592, which was referred to the Committee on Human Services. The Bill was adopted

on first and second readings on November 8, 2000, and December 5, 2000, respectively. Signed by the Mayor on December 22, 2000, it was assigned Act No. 13-541 and transmitted to both Houses of Congress for its review. D.C. Law 13-254 became effective on April 3, 2001.

§ 31-3832. Coverage for reconstructive surgery following mastectomies.

(a) An individual or group health plan which is a health benefit plan, and a health insurer providing health insurance coverage, that provides medical and surgical benefits with respect to a mastectomy shall, in a manner determined in consultation with the attending physician and the patient, provide the following coverage in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

(b) Coverage for the procedures in subsection (a) of this section may be subject to annual deductibles and coinsurance provisions as may be considered appropriate and as are consistent with those established for other benefits under the health benefit plan or coverage.

(Apr. 3, 2001, D.C. Law 13-254, § 3, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

§ 31-3833. Notice.

(a) Written notice of the availability of coverage, as set forth in § 31-3832, shall be delivered to the participant and beneficiary under the health plan upon enrollment and annually thereafter. Notice of the benefits shall be prominently positioned in any literature or correspondence made available or distributed by the health benefit plan or health insurer and shall be transmitted to the participant or beneficiary upon the earlier of:

(1) Any yearly informational packet sent to the participant or beneficiary, as part of the packet;

(2) In the next mailing made by the health benefit plan or health insurer to the participant or beneficiary; or

(3) Not later than 60 days after April 3, 2001.

(b) An individual or group health plan which is a health benefit plan, and a health insurer that has already provided notice in order to comply with the Women's Health and Cancer Rights Act of 1998, approved October 21, 1998 (112 Stat. 2681; 29 U.S.C. § 1185b, 42 U.S.C. § 300gg-6, and 42 U.S.C. § 300gg-52), need not provide additional notice under this chapter; provided, that it files with the Commissioner a written statement, with a copy of the notice attached, certifying that it is in compliance.

(Apr. 3, 2001, D.C. Law 13-254, § 4, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

§ 31-3834. Hormone replacement therapy coverage.

An individual or group health plan, and a health insurer offering health care coverage that provides coverage for prescription drugs, shall provide benefits which cover any hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

(Apr. 3, 2001, D.C. Law 13-254, § 5, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

§ 31-3835. Prohibitions.

An individual or group health plan which is a health benefit plan, and a health insurer offering health care coverage, shall not:

(1) Deny a patient eligibility, or continued eligibility, to enroll or renew coverage under terms of the health benefit plan, solely for the purpose of avoiding the requirements of this chapter; or

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this chapter.

(Apr. 3, 2001, D.C. Law 13-254, § 6, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

§ 31-3836. Regulations.

The Commissioner shall promulgate regulations necessary to implement the provisions of this chapter within 180 days after April 3, 2001.

(Apr. 3, 2001, D.C. Law 13-254, § 7, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

§ 31-3837. Applicability to group health plans.

The provisions of this chapter shall apply to group health benefit plans for years beginning on or after April 3, 2001.

(Apr. 3, 2001, D.C. Law 13-254, § 8, 48 DCR 723.)

Legislative history of Law 13-254. — For D.C. Law 13-254, see notes following § 31-3831.

CHAPTER 38B. HEALTH ORGANIZATIONS RBC.

Sec.	Sec.
31-3851.01. Definitions.	nouncements; prohibition on use
31-3851.02. RBC reports.	in rate making.
31-3851.03. Company Action Level Event.	31-3851.09. Foreign health organizations.
31-3851.04. Regulatory Action Level Event.	31-3851.10. Supplemental provisions; rules;
31-3851.05. Authorized Control Level Event.	exemption.
31-3851.06. Mandatory Control Level Event.	31-3851.11. Immunity.
31-3851.07. Hearings.	31-3851.12. Notices.
31-3851.08. Confidentiality; prohibition on an-	31-3851.13. Transition.

§ 31-3851.01. Definitions.

For the purposes of this chapter, the term:

(1) “Adjusted RBC report” means an RBC report which has been adjusted by the Commissioner in accordance with § 31-3851.02(c).

(2) “Authorized Control Level Event” means any of the following events:

(A) The filing of an RBC report by the health organization that indicates that the health organization’s total adjusted capital is at least equal to its Mandatory Control Level RBC, but less than its Authorized Control Level RBC;

(B) The notification by the Commissioner to the health organization of an adjusted RBC report described in subparagraph (A) of this paragraph; provided, that the health organization does not challenge the adjusted RBC report under § 31-3851.07;

(C) If, under § 31-3851.07, the health organization challenges an adjusted RBC report described in subparagraph (A) of this paragraph, notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization’s challenge;

(D) The failure of the health organization to respond, in a manner satisfactory to the Commissioner, to a corrective order; provided, that the health organization has not challenged the corrective order under § 31-3851.07; or

(E) If the health organization has challenged a corrective order under § 31-3851.07 and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(3) “Authorized Control Level RBC” means the amount of capital required under the risk-based capital formula in accordance with the RBC Instructions.

(4) “Commissioner” means Commissioner of the Department of Insurance and Securities Regulation.

(5) “Company Action Level Event” means any of the following events:

(A) The filing of an RBC report by a health organization that indicates that the health organization’s total adjusted capital is at least equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

(B) Notification by the Commissioner to the health organization of an adjusted RBC report described in subparagraph (A) of this paragraph; pro-

vided, that the health organization does not challenge the adjusted RBC report under § 31-3851.07; or

(C) If, under § 31-3851.07, a health organization challenges an adjusted RBC report described in subparagraph (A) of this paragraph, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(6) "Company Action Level RBC" means the Authorized Control Level RBC multiplied by a factor of 2.

(7) "Corrective order" means an order issued by the Commissioner specifying corrective actions.

(8) "District" means the District of Columbia.

(9) "Domestic health organization" means a health organization domiciled in the District.

(10) "Foreign health organization" means a health organization that is licensed to do business, but is not domiciled, in the District.

(11) "Health organization" means a health maintenance organization, hospital and medical indemnity or service corporation, or other managed care organization licensed under Chapter 34 of this title or Chapter 35 of this title. The term "health organization" shall not include an organization that is licensed as either a life and health insurer or a property and casualty insurer and that is otherwise subject to either the life or property and casualty RBC requirements.

(12) "Mandatory Control Level Event" means any of the following events:

(A) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its Mandatory Control Level RBC;

(B) Notification by the Commissioner to the health organization of an adjusted RBC report described in subparagraph (A) of this paragraph; provided, that the health organization does not challenge the adjusted RBC report under § 31-3851.07; or

(C) If, under § 31-3851.07, the health organization challenges an adjusted RBC report described in subparagraph (A) of this paragraph, notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(13) "Mandatory Control Level RBC" means the required Authorized Control Level RBC multiplied by a factor of 0.7.

(14) "NAIC" means the National Association of Insurance Commissioners.

(15) "RBC instructions" means the instructions for the RBC report, including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(16) "RBC level" means a health organization's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC.

(17) "RBC plan" means a comprehensive financial plan containing the elements specified in § 31-3851.03(a).

(18) "RBC report" means the report required by § 31-3851.02.

(19) “Regulatory Action Level Event” means any of the following events:

(A) The filing of an RBC report by the health organization that indicates that the health organization’s total adjusted capital is at least equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(B) Notification by the Commissioner to a health organization of an adjusted RBC report that described in subparagraph (A) of this paragraph; provided, that the health organization does not challenge the adjusted RBC report under § 31-3851.07;

(C) If, under § 31-3851.07, the health organization challenges an adjusted RBC report described in subparagraph (A) of this paragraph, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the health organization’s challenge;

(D) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

(E) The failure of the health organization to submit an RBC plan to the Commissioner within the time period set forth in § 31-3851.03(b);

(F) Notification by the Commissioner to the health organization stating that:

(i) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the Commissioner, unsatisfactory; and

(ii) The notification constitutes a Regulatory Action Level Event with respect to the health organization; provided, that the health organization has not challenged the determination under § 31-3851.07;

(G) If, under § 31-3851.07, the health organization challenges a determination by the Commissioner under subparagraph (F) of this paragraph, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the challenge;

(H) Notification by the Commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan; provided, that the failure has a substantial adverse effect on the ability of the health organization to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification; provided further, that the health organization has not challenged the determination under § 31-3851.07; or

(I) If, under § 31-3851.07, the health organization challenges a determination by the Commissioner under subparagraph (H) of this paragraph, the notification by the Commissioner to the health organization that the Commissioner has, after a hearing, rejected the challenge.

(20) “Regulatory Action Level RBC” means the Authorized Control Level RBC multiplied by a factor of 1.5.

(21) “Revised RBC plan” means, if the Commissioner rejects the RBC plan, the RBC plan as revised by the health organization, with or without the Commissioner’s consent.

(22) “Total adjusted capital” means the sum of:

(A) A health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed; and

(B) Such other items, if any, as the RBC instructions may require.

(June 18, 2003, D.C. Law 14-312, § 101, 50 DCR 306; Apr. 13, 2005, D.C. Law 15-354, § 45(a), 52 DCR 2638.)

Effect of amendments. — D.C. Law 15-354, in par. (11), validated a previously made technical correction.

Legislative history of Law 14-312. — Law 14-312, the "Health Organizations RBC Amendment Act of 2002", was introduced in Council and assigned Bill No. 14-159, which was referred to the Committee on Human Services. The Bill was adopted on first and second

readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 23, 2002, it was assigned Act No. 14-571 and transmitted to both Houses of Congress for its review. D.C. Law 14-312 became effective on June 18, 2003.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

§ 31-3851.02. RBC reports.

(a) A domestic health organization shall, prior to each March 2 ("filing date"), prepare and submit to the Commissioner a report of its RBC levels as of the end of the previous calendar year, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health organization shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

(A) Fifteen days after the receipt of notice to file its RBC report with that state; or

(B) The filing date.

(b) A health organization's RBC level shall be determined in accordance with the RBC instructions.

(c) If a domestic health organization files an RBC report that, in the judgment of the Commissioner, is inaccurate, the Commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment.

(June 18, 2003, D.C. Law 14-312, § 102, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.03. Company Action Level Event.

(a) If a Company Action Level Event occurs, the health organization shall prepare and submit to the Commissioner an RBC plan that shall:

(1) Identify the conditions that contributed to the Company Action Level Event;

(2) Contain proposals of corrective actions that the health organization proposes to eliminate the Company Action Level Event;

(3) Provide forecasts of the health organization's financial results in the current year and at least the 2 succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels; provided, that the forecasts for both new and renewal business may include separate forecasts for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the health organization's forecasts and the sensitivity of the forecasts to the assumptions; and

(5) Identify the quality of, and problems associated with, the health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any.

(b) The RBC plan shall be submitted:

(1) Within 45 days of the Company Action Level Event other than if a company challenges an adjusted RBC report; or

(2) If the health organization challenges an adjusted RBC report, within 45 days after notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(c) Within 60 days after the submission by a health organization of an RBC plan to the Commissioner, the Commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination and may set forth proposed revisions which will render the RBC plan satisfactory. Upon notification from the Commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

(1) Within 45 days after the notification from the Commissioner; or

(2) If the health organization challenges the notification from the Commissioner under § 31-3851.07, within 45 days after a notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(d) If the Commissioner notifies a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may, at the Commissioner's discretion, subject to the health organization's right to a hearing under § 31-3851.07, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(e) A domestic health organization that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(1) The state has a risk-based capital provision substantially similar to § 31-3851.08(a); and

(2) The insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date on which the RBC plan or revised RBC plan is filed under subsection (b) or (c) of this section.

(June 18, 2003, D.C. Law 14-312, § 103, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.04. Regulatory Action Level Event.

(a) If a Regulatory Action Level Event occurs, the Commissioner shall:

(1) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the Commissioner considers necessary of the assets, liabilities, and operations of the health organization, including a review of its RBC plan or revised RBC plan; and

(3) Issue a corrective order.

(b) In determining corrective action, the Commissioner may consider factors which include the results of any sensitivity tests undertaken under the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within 45 days after the occurrence of the Regulatory Action Level Event;

(2) If the health organization challenges an adjusted RBC report under § 31-3851.07, and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge; or

(3) If the health organization challenges a revised RBC plan under § 31-3851.07, and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the health organization that the Commissioner has, after a hearing, rejected the health organization's challenge.

(c) The Commissioner may retain actuaries, investment experts, or other consultants as may be necessary in the judgment of the Commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations (including contractual relationships) of the health organization, and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to the actuaries, investment experts, or consultants shall be borne by the affected health organization or such other party as directed by the Commissioner.

(June 18, 2003, D.C. Law 14-312, § 104, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.05. Authorized Control Level Event.

- (a) If an Authorized Control Level Event occurs, the Commissioner shall:
- (1) Take such actions as are required under § 31-3851.04 with respect to a Regulatandy Action Level Event; and
 - (2) If the Commissioner considers it to be in the best interests of the policyholders and creditors of the health organization and of the public, take such action as is necessary to cause the health organization to be placed under regulatory control under Chapter 34 of this title and Chapter 13 of this title.
- (b)(1) If the Commissioner takes action under subsection (a)(1) of this section pursuant to an adjusted RBC report, the health organization shall be entitled to the protections which are afforded to health organizations under Chapter 34 of this title and Chapter 13 of this title pertaining to summary proceedings.
- (2) If the Commissioner takes action under subsection (a)(2) of this section, the Authorized Control Level Event shall be sufficient for the Commissioner to take action under Chapter 34 of this title or Chapter 13 of this title. In such event, the Commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in Chapter 34 of this title and Chapter 13 of this title.

(June 18, 2003, D.C. Law 14-312, § 105, 50 DCR 306; Apr. 13, 2005, D.C. Law 15-354, § 45(b), 52 DCR 2638.)

Effect of amendments. — D.C. Law 15-354, in pars. (1) and (2) of subsec. (a), substituted “and” for “or”.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.06. Mandatory Control Level Event.

- (a) If a Mandatory Control Level Event occurs, the Commissioner shall take such action as is necessary to place the health organization under regulatory control under Chapter 34 of this title or Chapter 13 of this title. In such event, the Mandatory Control Level Event shall be sufficient reason for the Commissioner to take action under Chapter 34 of this title or Chapter 13 of this title. In such event, the Commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in Chapter 34 of this title and Chapter 13 of this title.
- (b) If the Commissioner takes action under subsection (a) of this section pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of Chapter 34 of this title and Chapter 13 of this title pertaining to summary proceedings.
- (c) Notwithstanding the provisions of subsections (a) or (b) of this section, the Commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expecta-

tion that the Mandatory Control Level Event may be eliminated within the 90-day period.

(June 18, 2003, D.C. Law 14-312, § 106, 50 DCR 306; Apr. 13, 2005, D.C. Law 15-354, § 45(c), 52 DCR 2638.)

Effect of amendments. — D.C. Law 15-354, in subsecs. (a) and (b), validated a previously made technical corrections.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.07. Hearings.

(a) A health organization may request a confidential department hearing, on a record, to challenge a determination or action if the Commissioner notifies it of the following:

(1) An adjusted RBC report;

(2)(A) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(B) The notification constitutes a Regulatory Action Level Event;

(3) The health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan; or

(4) A corrective order.

(b) The health organization shall notify the Commissioner of its request for a hearing within 5 days after a notification described in subsection (a) of this section. Upon receipt of the health organization's request for a hearing, the Commissioner shall set a date for the hearing, which shall be no less than 10, or more than 30, days after the date of the health organization's request.

(June 18, 2003, D.C. Law 14-312, § 107, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.08. Confidentiality; prohibition on announcements; prohibition on use in rate making.

(a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health organization performed under this chapter and any corrective order issued by the Commissioner under examination or analysis) that are filed with the Commissioner shall be confidential and privileged, shall not be subject to subchapter II of Chapter 5 of Title 2, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in a private civil action; provided, that the Commissioner may use the documents, materials, or other information in furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(b) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not be permitted or required to testify in a private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) To assist in the performance of the Commissioner's duties under this chapter, the Commissioner may:

(1) Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, with District, state, federal, and international regulatory agencies, with the NAIC, and with District, state, federal, and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of document, material, or other information;

(2) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential and privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; or

(3) Enter into agreements governing sharing and use of the information consistent with this subsection.

(d) No waiver of an existing privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of sharing as authorized in subsection (c)(3) of this section.

(e) Except as otherwise required under this chapter, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation, or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker, or other person engaged in any manner in the insurance business shall be prohibited; provided, that if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the health organizations' RBC levels is published in any written publication and the health organization is able to demonstrate to the Commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(f) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans shall only be used by the Commissioner in monitoring

the solvency of health organizations and the need for possible corrective action and shall not be used by the Commissioner for ratemaking, or considered or introduced as evidence in any rate proceeding, nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or an affiliate is authorized to write.

(June 18, 2003, D.C. Law 14-312, § 108, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.09. Foreign health organizations.

(a)(1) A foreign health organization shall, upon the written request of the Commissioner, submit to the Commissioner an RBC report as of the end of the previous calendar year upon the later of:

(A) The date that an RBC report would be required to be filed by a domestic health organization under this chapter; or

(B) Fifteen days after the request is received by the foreign health organization.

(2) A foreign health organization shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(b) If (1) a Company Action Level Event, Regulatory Action Level Event, or Authorized Control Level Event occurs with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization (or, if no RBC statute is in force in that state, under the provisions of this chapter), and (2) the Insurance Commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under § 31-3851.03), the Commissioner may require the foreign health organization to file an RBC plan with the Commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the Commissioner shall be reason to order the health organization to cease and desist from writing new insurance business in the District.

(c) If (1) a Mandatory Control Level Event occurs with respect to a foreign health organization, and (2) no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the Commissioner may apply to the Superior Court of the District of Columbia as permitted under Chapter 34 of Title 31 or Chapter 13 of Title 31 with respect to the liquidation of property of foreign health organizations found in the District of Columbia. The occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

(June 18, 2003, D.C. Law 14-312, § 109, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.10. Supplemental provisions; rules; exemption.

(a) This chapter shall supplement the other provisions of the laws of the District and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including Chapter 34 of this title and Chapter 13 of this title.

(b) The Commissioner may promulgate regulations to implement this chapter.

(c) The Commissioner may exempt from the application of this chapter a domestic health organization that:

(1) Writes direct business only in the District;

(2) Assumes no reinsurance in excess of 5% of direct premium written; and

(3) Writes direct annual premiums for comprehensive medical business of \$2 million or less.

(June 18, 2003, D.C. Law 14-312, § 110, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.11. Immunity.

The Commissioner, the Department of Insurance and Securities Regulation, or its employees or agents shall not be liable for any action taken by them in the performance of their powers and duties under this chapter.

(June 18, 2003, D.C. Law 14-312, § 111, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.12. Notices.

All notices by the Commissioner to a health organization that may result in regulatory action under this chapter shall be effective upon mailing if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the health organization's receipt of notice.

(June 18, 2003, D.C. Law 14-312, § 112, 50 DCR 306.)

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

§ 31-3851.13. Transition.

For RBC reports required to be filed by health organizations with respect to 2002, the following requirements shall apply in lieu of the provisions of §§ 31-3851.03, 31-3851.04, 31-3851.05, and 31-3851.06:

(1) In the event of a Company Action Level Event with respect to a

domestic health organization, the Commissioner shall take no regulatory action under this chapter.

(2) In the event of a Regulatory Action Level Event as defined under § 31-3851.01(19)(A) through (C), the Commissioner shall take the actions required under § 31-3851.03.

(3) In the event of a Regulatory Action Level Event as defined under § 31-3851.01(19)(D) through (I), or an Authorized Control Level Event, the Commissioner shall take the action required under § 31-3851.04 with respect to the health organization.

(4) In the event of a Mandatory Control Level Event, the Commissioner shall take the action required under § 31-3851.05.

(June 18, 2003, D.C. Law 14-312, § 113, 50 DCR 306; Apr. 13, 2005, D.C. Law 15-354, § 45(d), 52 DCR 2638.)

Effect of amendments. — D.C. Law 15-354 validated previously made technical corrections.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 14-312. — For Law 14-312, see notes following § 31-3851.01.

SUBTITLE V. LIABILITY AND RELATED INSURANCE.

CHAPTER 39. CAPTIVE INSURANCE COMPANIES (2000) [REPEALED].

Sec.

31-3901 to 31-3918. [Repealed].

§ 31-3901. Definitions. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 2, 47 DCR 7320; June 11, 2004, D.C. Law 15-166, § 4(x), 51 DCR 2817; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(a) of Captive Insurance Company Temporary Amendment Act of 2004 (D.C. Law 15-151, April 22, 2004, law notification 51 DCR 4935).

For temporary (225 day) amendment of section, see § 4(a) of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Temporary Addition of Section. — For temporary (225 day) additions, see §§ 2 to 16 of District of Columbia Free Clinic Captive Insurance Company Establishment Temporary Act of 2007 (D.C. Law 17-63, December 11, 2007, law notification 55 DCR 438).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2(a) of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-346, January 29, 2004, 51 DCR 1834).

For temporary (90 day) amendment of section, see § 4(x) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

For temporary (90 day) amendment of section, see § 4(a) of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) amendment of section, see § 4(a) of Captive Insurance Company

Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — Law 13-192, the “Captive Insurance Company Act of 2000,” was introduced in Council and assigned Bill No. 13-707, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-420 and transmitted to both Houses of Congress for its review. D.C. Law 13-192 became effective on October 21, 2000.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 15-262. — Law 15-262, the “Captive Insurance Company Act of 2004,” was introduced in Council and assigned Bill No. 15-834, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 5, 2004, and November 9, 2004, respectively. Signed by the Mayor on November 30, 2004, it was assigned Act No. 15-638 and transmitted to both Houses of Congress for its review. D.C. Law 15-262 became effective on March 17, 2005.

§ 31-3902. Authority to do business—Certificate of authority. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 3, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3903. Authority to do business—application requirements. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 4, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3904. Authority to do business—revocation or suspension. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 5, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3905. Name. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 6, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3906. Organizational requirements for transacting business; incorporation. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 7, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2(b) of Captive Insurance Company Temporary Amendment Act of 2004 (D.C. Law 15-151, April 22, 2004, law notification 51 DCR 4935).

For temporary (225 day) amendment of section, see § 4(b) of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2(b) of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-346, January 29, 2004, 51 DCR 1834).

For temporary (90 day) amendment of sec-

tion, see § 4(b) of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) amendment of section, see § 4(b) of Captive Insurance Company Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3907. Requirements for transacting business. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 8, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3908. Minimum capital and surplus requirements. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 9, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4(d) of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(d) of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) amendment of sec-

tion, see § 4(d) of Captive Insurance Company Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3909. Annual report. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 10, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3910. Financial examination. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 11, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3911. Investments. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 12, 47 DCR 7320; April 11, 2003, D.C. Law 14-297, § 401(d), 50 DCR 330; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Effect of amendments. — D.C. Law 14-297, in subsec. (a), substituted “Chapter 13A of this title” for “§ 31-2502.18”.

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3912. Reinsurance. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 13, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3913. Rating organization. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 14, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3914. Insolvency. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 15, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3915. Tax on premiums collected. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 16, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3916. Captive Insurance Regulatory and Supervision Trust Account. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 17, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Temporary Addition of Section. — For temporary (225 day) additions, see § 4(c) of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Emergency legislation. — For temporary (90 day) additions, see § 4(c) of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) additions, see § 4(c)

of Captive Insurance Company Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3917. Regulations. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 18, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-3918. Laws applicable. [Repealed].

Repealed.

(Oct. 21, 2000, D.C. Law 13-192, § 18, 47 DCR 7320; Mar. 17, 2005, D.C. Law 15-262, § 24(a), 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) repeal of section and transition provisions, see § 24 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 13-192. — For Law 13-192, see notes following § 31-3901.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

CHAPTER 39A. CAPTIVE INSURANCE COMPANIES (2004).

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*Subchapter I. General.***§ 31-3931.01. Definitions.**

For the purposes of this chapter, the term:

(1) "Affiliated company" means a company in the same corporate system as its parent or a member organization by virtue of common ownership, control, operation, or management.

(2) "Agency captive insurer" means a captive insurer that is owned by an insurance agency or brokerage and that only insures risks of policies that are placed by or through the agency or brokerage.

(3) "Alien captive insurer" means any non-U.S. insurance company formed to write insurance business for its parents and affiliates and licensed pursuant to the laws of a foreign country that imposes statutory or regulatory standards in a form acceptable to the Commissioner on companies transacting the business of insurance in the jurisdiction.

(4) "Association" means a legal entity consisting of 2 or more individuals, corporations, partnerships, associations, or other forms of business organization.

(5) "Association captive insurer" means a captive insurer that only insures risks of the member organizations of an association and the affiliated companies of those members, including groups formed pursuant to the Product Liability Risk Retention Act of 1981, approved September 25, 1981 (95 Stat.

949; 15 U.S.C. § 3901 et seq.), and the employee benefit plans or trusts of such organizations or companies.

(6) "Branch business" means any insurance business transacted by a branch captive insurance company in the District.

(7) "Branch captive insurer" means any alien captive insurer licensed by the Commissioner to transact the business of insurance in the District through a business unit with a principal place of business in the District.

(8) "Branch operations" means any business operations of a branch captive insurer in the District.

(9) "Captive insurer" means any insurer that insures the risks of its parent or affiliated companies of its parent, any member organizations of an association and the affiliated companies of the member organizations, or any other policyholders or participants that have entered into a contractual relationship with the insurer for the purchase of insurance, including any pure captive insurer, association captive insurer, agency captive insurer, segregated account captive insurer, and rental captive insurer licensed pursuant to this chapter.

(10) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(11) "Common ownership and control" means:

(A) In the case of a stock insurer, the direct or indirect ownership of 51% or more of the voting stock of 2 or more corporations by the same member or members; and

(B) In the case of a mutual insurer, the direct or indirect ownership of 51% or more of the surplus and the voting power of 2 or more corporations by the same member or members.

(12) "Department" means the Department of Insurance, Securities, and Banking.

(13) "Excess workers' compensation insurance" means insurance in excess of the specified per-incident or aggregate limit, if any, established by:

(A) The Commissioner, if the insurance is being transacted in the District; or

(B) The chief regulatory officer for insurance in the jurisdiction in which the insurance is being transacted.

(14) "Member organization" means any individual, corporation, partnership, association, or other form of business organization that belongs to an association.

(15) "Mutual insurer" means an incorporated insurer without any issued and outstanding stock whose capital and surplus are owned by its policyholders.

(16) "Net direct premiums" means the direct premiums collected or contracted for on policies or contracts of insurance written by a captive insurer during the preceding calendar year, less the amounts paid to policyholders as return premiums, including dividends on unabsorbed premiums or premium deposits returned or credited to policyholders.

(17) "Parent" means a corporation, partnership, association, or other form of business organization that directly or indirectly owns, controls, or holds

power to vote more than 51% or more of the outstanding voting securities of a pure captive insurer.

(18) "Participant" means any individual or organization, and any affiliates thereof, that are insured by a segregated account captive insurer if the losses of the person are limited through a participant contract to the assets of a segregated account.

(19) "Participant contract" means a contract by which a segregated account captive insurer insures the risks of a participant and limits the losses of the participant to the assets of the segregated account.

(20) "Person" means any individual, corporation, partnership, limited liability company, limited liability partnership, joint venture, an association, joint stock company, trust, unincorporated organization, similar entity, or any combination of the foregoing.

(21) "Provisional certificate of authority" means a certificate of authority issued to a captive insurer that authorizes the captive insurer to engage in limited activities authorized by the Commissioner.

(22) "Pure captive insurer" means a captive insurer that only insures or reinsures risks of its parent and affiliated companies or controlled unaffiliated business. The parent of a pure captive insurer includes an employee benefit plan or trust.

(23) "Reciprocal insurer" includes an interinsurance exchange or a risk retention group as defined in § 31-4101(12).

(24) "Redomestication" means the transfer to the District of the insurance domicile of an authorized foreign or alien insurance company.

(25) "Rental captive insurer" means a captive insurer formed to enter into contractual agreements with policyholders or associations to offer some or all of the benefits of a program of captive insurance and that only insures risks of the policyholders or associations.

(26) "Segregated account" means a separate account established and maintained by any captive insurer:

(A) In which the minimum capital and surplus required by applicable law is provided by one or more persons;

(B) That is formed or licensed under the provisions of this chapter;

(C) That insures risks of separate participants through contract;

(D) That is comprised of one or more participants who are authorized to act on matters relating to the segregated account; and

(E) That segregates each participant's liability through one or more segregate accounts.

(27) "Stock insurer" means an incorporated insurer with issued and outstanding stock whose capital and surplus is owned by its stockholders.

(Mar. 17, 2005, D.C. Law 15-262, § 2, 52 DCR 1205.)

Cross references. — Dissolution of the District of Columbia Free Clinic Captive Insurance Company, see § 1-307.94.

Emergency legislation. — For temporary (90 day) addition of section, see § 2 of Captive

Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

For temporary (90 day) additions, see §§ 2 to 17 of District of Columbia Free Clinic Captive

Insurance Company Establishment Emergency Act of 2007 (D.C. Act 17-113, October 3, 2007, 54 DCR 9977).

Legislative history of Law 15-262. — Law 15-262, the “Captive Insurance Company Act of 2004”, was introduced in Council and assigned Bill No. 15-834, which was referred to the Committee on Consumer and Regulatory Af-

fairs. The Bill was adopted on first and second readings on October 5, 2004, and November 9, 2004, respectively. Signed by the Mayor on November 30, 2004, it was assigned Act No. 15-638 and transmitted to both Houses of Congress for its review. D.C. Law 15-262 became effective on March 17, 2005.

§ 31-3931.02. Authority to do business; prohibited activities.

(a) A captive insurer may be organized and operated in any form of business organization authorized by the Commissioner and may, pursuant to this chapter, transact any insurance or annuity business.

(b) Notwithstanding subsection (a) of this section, a captive insurer shall not:

(1) Directly provide personal motor vehicle or homeowners’ insurance coverage, or any component thereof;

(2) Accept or cede reinsurance, except as otherwise provided in § 31-3931.08;

(3) Insure any risks other than those of its parent and affiliated companies if it is a pure captive insurer;

(4) Insure any risks other than those of the member organizations of its association and the affiliated companies of the member organizations if it is an association captive insurer;

(5) Insure any risks other than those of the policies that are placed by or through the insurance agency or brokerage that owns the captive insurer if it is an agency captive insurer;

(6) Insure any risks other than those of the policyholders or associations that have entered into agreements with the rental captive insurer for the insurance of those risks if it is a rental captive insurer, and shall use a form approved by the Commissioner for these agreements;

(7) Provide excess workers’ compensation insurance to its parent and affiliated companies if the transaction is prohibited by the laws of the state in which the insurance is transacted;

(8) Reinsure workers’ compensation insurance provided pursuant to a program of self-funded insurance of its parent and affiliated companies unless:

(A) The parent or affiliated company which is providing the self-funded insurance is certified as a self-insured employer by the Commissioner, if the insurance is being transacted in the District; or

(B) The program of self-funded insurance is otherwise qualified pursuant to, or in compliance with, the laws of the state in which the insurance is transacted; or

(9) Write insurance or reinsurance for employee benefits that are subject to the provisions of the provisions of the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 832; 29 U.S.C. § 1001 et seq.), for any entity except its parent and affiliated companies.

(c) Notwithstanding subsections (a) and (b) of this section, the Commissioner may authorize a captive insurer that is otherwise qualified to conduct

business in the District to engage in any activity in any form permitted by a captive insurer in any other jurisdiction.

(d) A captive insurer shall file with the Commissioner a written request to engage in any activity under subsection (c) of this section. The Commissioner shall approve the request within 30 days after receiving the request, unless the Commissioner determines that the activity will be harmful to the captive insurer's policyholders.

(e) For the purposes of this chapter, a branch captive insurer shall be deemed to be a pure captive insurer with respect to operations in the District, unless otherwise permitted by the Commissioner.

(Mar. 17, 2005, D.C. Law 15-262, § 3, 52 DCR 1205; Apr. 7, 2006, D.C. Law 16-91, § 102(a), 52 DCR 10637; Mar. 2, 2007, D.C. Law 16-191, § 54(a), 53 DCR 6794.)

Effect of amendments. — D.C. Law 16-91, in par. (b)(2), substituted “§ 31-3931.08” for “§ 31-3931.07”.

D.C. Law 16-191, in subsec. (b)(2), validated a previously made technical correction.

Emergency legislation. — For temporary (90 day) addition of section, see § 3 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-91. — Law

16-91, the “Technical Amendments Act of 2005”, was introduced in Council and assigned Bill No. 16-477 which was referred to the Committee on the Whole. The Bill was adopted on first and second readings on November 1, 2005, and November 15, 2005, respectively. Signed by the Mayor on November 30, 2005, it was assigned Act No. 16-212 and transmitted to both Houses of Congress for its review. D.C. Law 16-91 became effective on April 7, 2006.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

§ 31-3931.03. Organizational requirements for transacting business; incorporation.

(a) A captive insurer may be organized in the District in any form of authorized by the Commissioner.

(a-1) The articles of incorporation of a captive insurer shall become effective when approved by the Commissioner.

(b) The articles of incorporation or organizational documents of a captive insurer shall satisfy the following minimum requirements:

(1) The capital stock of a captive insurer incorporated as a stock insurer shall be issued at not less than par value;

(2) The captive insurer shall not have less than 2 incorporators or organizers;

(3) The articles of association, articles of incorporation, articles of organization, charter, or bylaws of a captive insurer shall require a quorum of the board of directors that consists of more than $\frac{1}{3}$ of the number of directors prescribed by the articles of association, articles of incorporation, articles of organization (or equivalent organizational document), charter, or bylaws; and

(4) Any additional provisions that the Commissioner considers necessary.

(c) The Commissioner may, at the request of the captive insurer, issue a certificate of good standing and charge a fee for each certificate in an amount to be established by the Commissioner.

(d) An attorney-in-fact of a reciprocal captive insurer may be organized in

the District in any form of business, including as an individual, authorized by the Commissioner.

(e) A captive insurer organized in the District shall have the privileges of, and shall be subject to, the provisions of Chapters 1, 2, 3, 4, and 8 of Title 29. If the provisions of this chapter conflict with the general provisions of Title 29, the provisions of this chapter shall control.

(f) The Commissioner may regulate the manager of a captive insurer.

(Mar. 17, 2005, D.C. Law 15-262, § 4, 52 DCR 1205; Mar. 2, 2007, D.C. Law 16-191, § 54(b), 53 DCR 6794; July 2, 2011, D.C. Law 18-378, § 3(w), 58 DCR 1720; Mar. 14, 2012, D.C. Law 19-103, § 2(a), 59 DCR 432.)

Effect of amendments. — D.C. Law 16-191, in subsec. (e), validated a previously made technical correction.

D.C. Law 18-378, in subsec. (e), substituted “Chapters 1, 2, 3, 4, and 8 of Title 29” for “general corporation law set forth in Chapter 1 of Title 29, subchapter I of Chapter 3 of Title 29, and Chapter 10 of Title 29, and the applicable provisions contained in this chapter”, and substituted “general provisions in Title 29” for “general provisions of the acts codified in Title 29”.

D.C. Law 19-103 added subsec. (a-1).

Emergency legislation. — For temporary (90 day) addition of section, see § 4 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Legislative history of Law 18-378. — For history of Law 18-378, see notes under § 31-754.

Legislative history of Law 19-103. — Law 19-103, the “Captive Insurance Company Amendment Act of 2012”, was introduced in Council and assigned Bill No. 19-149, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on December 6, 2011, and January 4, 2012, respectively. Signed by the Mayor on January 20, 2012, it was assigned Act No. 19-278 and transmitted to both Houses of Congress for its review. D.C. Law 19-103 became effective on March 14, 2012.

§ 31-3931.04. Protected cell captive insurers.

(a) For the purposes of this section, the term:

(1) “Incorporated protected cell” means a protected cell that is established as a corporation or other legal entity separate from the protected cell captive insurer of which it is a part.

(2) “Protected cell” means a separate account established and maintained by a protected cell captive insurer and shall include an incorporated protected cell

(3) “Protected cell captive insurer” means a captive insurer that:

(A) Is formed and licensed under the provisions of this chapter;

(B) Insures the risks of separate participants through a contract; and

(C) Segregates each participant’s liability through one or more protected cells.

(b)(1) A captive insurer may be organized as a protected cell captive insurer and shall be permitted to form one or more protected cells under this chapter to insure risks of one or more participants. The assets and liabilities of each protected cell shall be held separately from the assets and liabilities of all other protected cells.

(2) A protected cell captive insurer may be organized and operated in any form of business organization authorized by the Commissioner.

(3) An incorporated protected cell may be organized and operated in any form of business organization authorized by the Commissioner.

(4) A protected cell captive insurer shall, at the time of paying the annual fee, pay an additional annual fee for each protected cell in an amount to be established by the Commissioner.

(5) Each incorporated protected cell of a protected cell captive insurer shall be treated as a captive insurer for purposes of this chapter.

(6) Unless otherwise permitted by the articles of incorporation or other organizational document of a protected cell captive insurer, each incorporated protected cell of the protected cell captive insurer shall have the same directors, secretary, and registered office as the protected cell captive insurer.

(7) A protected cell captive insurer may provide that a protected cell it creates shall be wound up and dissolved upon:

(A) The bankruptcy, death, expulsion, insanity, resignation or retirement of any participant of the protected cell;

(B) The happening of some other event that is not the expiration of a fixed period of time; or

(C) The expiration of a fixed period of time.

(8) The articles of incorporation of a protected cell captive insurer:

(A) Shall provide that a protected cell shall not own shares in the protected cell captive insurer of which it is a part; and

(B) May provide that a protected cell may own shares in any other protected cell of the protected cell captive insurer.

(9) The name of a protected cell captive insurer shall include the words "Protected cell captive" or the abbreviation "PCC".

(10) A name that includes the words "Protected cell captive" may, in setting out or using its name for any purpose under this chapter, do so in full or in the abbreviated form.

(11) A protected cell captive insurer shall assign a distinctive name to each of its protected cells that is not an incorporated protected cell that:

(A) Identifies the protected cell as being part of the protected cell captive insurer;

(B) Distinguishes the protected cell from any other protected cell of the protected cell captive insurer; and

(C) Includes the words "Protected Cell" or the abbreviation "PC".

(12) An incorporated protected cell must include the words "Incorporated Cell" or the abbreviation "IC".

(13) Any captive insurer or protected cell formed prior to March 14, 2007, shall not be required to change its name or the designation of any of its protected cells to comply with the provisions of paragraphs (6), (8), or (9) of this subsection.

(14) A protected cell of a protected cell captive insurer, unless created as an incorporated protected cell, has no legal identity separate from that of the protected cell captive insurer of which it is a part.

(15) A protected cell of a protected cell captive insurer may enter into an agreement with its protected cell captive insurer or with another protected cell of the protected cell captive insurer that shall be enforceable as if each

protected cell of the protected cell captive insurer were a separate legal entity, even if the protected cell is not organized as an incorporated protected cell.

(16) The assets of a protected cell captive insurer shall be cell assets or general assets. The cell assets comprise the assets of the protected cell captive insurer that are held within or on behalf of its protected cells. The general assets of a protected cell captive insurer comprise the assets of the protected cell captive insurer that are not cell assets.

(17) The liabilities of a protected cell captive insurer shall be cell liabilities or general liabilities. The cell liabilities comprise the obligations of the protected cell captive insurer attributed to its protected cells. The general liabilities of a protected cell captive insurer comprise the obligations of the protected cell captive insurer that are not cell liabilities.

(18) Each protected cell shall be accounted for separately on the books and records of the protected cell captive insurer to reflect the financial condition and results of operations of each protected cell, including net income or loss, dividends or other distributions to participants, and such other factors as may be provided by the participant contract or required by the Commissioner.

(19) Each protected cell captive insurer shall annually file with the Commissioner such financial reports as the Commissioner shall require, which reports shall include financial statements detailing the financial experience of each protected cell.

(20) The captive manager of a protected cell captive insurer shall immediately notify the Commissioner if any protected cell of the protected cell captive insurer becomes insolvent or is otherwise unable to meet its claims or other obligations.

(21) A protected cell captive insurer may create and issue shares in one or more classes or series for one or more protected cells. The proceeds of the issue shall be included in the assets of the protected cell that issued the shares.

(22) The proceeds of the issue of shares, other than protected cell shares, shall be included in the protected cell captive insurer's general assets.

(23) A protected cell captive insurer may pay a dividend on protected cell shares of any class or series whether or not a dividend is declared on any other class or series of protected cell shares or any other shares.

(24) Dividends may be paid on protected cell shares only from the cell assets of the protected cell that issued the shares and otherwise in accordance with the rights of such shares.

(25) No sale, exchange, or other transfer of assets may be made by a protected cell captive insurer between or among any of its protected cells without the written consent of the participants of the protected cell and the Commissioner.

(26) No sale, exchange, transfer of assets, dividend, or distribution may be made from a protected cell to any person without the Commissioner's prior written approval. An approval shall not be given if the sale, exchange, transfer, dividend, or distribution will result in the insolvency or impairment with respect to a protected cell.

(27) The owners of a protected cell captive insurer, shall not, by virtue of being owners, be the owners or participants of any protected cell of the protected cell captive insurer.

(28) The participants of a protected cell shall not, by virtue of being such participants, be the owners of the protected cell captive insurer or participants or owners of any other protected cell of the protected cell captive insurer.

(29) Any individual or legal entity may be a participant in a protected cell formed under this chapter.

(30) A participant in a protected cell need not be a shareholder of the protected cell or of the protected cell captive insurer or any affiliate thereof.

(31) No participant contract shall take effect without the Commissioner's prior written approval. The addition of each new protected cell or the withdrawal or other transfer of any participant from any existing protected cell shall constitute a change in the strategic business plan of that protected cell requiring the Commissioner's prior written approval.

(32) A protected cell captive insurer shall, in addition to keeping a register of its owners or participants, keep a register of the participants of each of its protected cells.

(33) If a protected cell captive insurer (A) enters into a transaction in respect of a particular protected cell of the protected cell captive insurer, or (B) incurs a liability arising from an activity or asset of a particular protected cell, a claim by any person in connection with the transaction or liability extends only to the cell assets of the protected cell.

(34) If a protected cell captive insurer (A) enters into a transaction in its own right and not in respect of any of its protected cells, (B) incurs a liability arising from an activity its own right and not in respect of any of its protected cells, or (C) incurs a liability arising from an asset held in its own right and not in respect of any of its protected cells, a claim by any person in connection with the transaction or liability shall extend only to the general assets of the protected cell captive insurer.

(35) Except as provided by paragraphs (37) and (39) of this subsection, a protected cell captive insurer shall not satisfy any liability:

(A) Attributable to a particular protected cell of the protected cell captive insurer from the general assets of the protected cell captive insurer; or

(B) Whether attributable to a particular protected cell or not, from the cell assets of another protected cell of the protected cell captive insurer.

(36) If (A) a protected cell captive insurer is permitted to do so under its articles of incorporation or similar organizational documents, and (B) the requirement set forth in paragraph (68) of this subsection is satisfied, the protected cell captive insurer may satisfy any liability attributable to a particular protected cell from the protected cell captive insurer's general assets.

(37) Prior to a protected cell captive insurer satisfying any liability attributable to a particular protected cell from the protected cell captive insurer's general assets, the directors who authorize the satisfaction of the liability shall state as part of the authorization that, having made the inquiry into the affairs and prospects of the protected cell captive insurer, they have formed the opinion that:

(A) Immediately following the date on which the liability is proposed to be met by the general assets of the protected cell captive insurer, the protected cell captive insurer will be able to discharge its liabilities as they fall due; and

(B) Having regard to the prospects of the protected cell captive insurer, the intentions of the directors with respect to the management of the protected cell captive insurer's business, and the amount and character of the financial resources that will, in their view, be available to the protected cell captive insurer, the protected cell captive insurer will be able to continue to carry on business and will be able to discharge its liabilities as they fall due until the expiration of the period of one year immediately following the date on which the liability is proposed to be satisfied by the general assets of the protected cell captive insurer or until the protected cell captive insurer is dissolved, whichever first occurs.

(38) A protected cell captive insurer may satisfy any liability, whether attributable to a particular protected cell or not, from the cell assets of another protected cell if:

(A) It is permitted to do so by the articles of incorporation or other organizational document of that other protected cell, in the case of an incorporated protected cell, or by the participant contract, in the case of all other protected cells; and

(B) Prior to the protected cell captive insurer satisfying any liability from the cell assets of that other protected cell, the directors who authorize the satisfaction of the liability shall obtain written approval from the Commissioner, upon first having made full inquiry into the affairs and prospects of that protected cell, and stating, as part of the authorization, that they have formed the opinion that:

(i) Immediately following the date on which the liability is proposed to be met by the cell assets of the protected cell, the protected cell will be able to discharge its liabilities as they fall due; and

(ii) Having regard to the prospects of the protected cell, the intentions of the directors with respect to the management of the protected cell's business, and the amount and character of the financial resources that will in their view be available to the protected cell, the protected cell will be able to continue to carry on business and will be able to discharge its liabilities as they become due or until the protected cell is dissolved, whichever first occurs.

(39) A director who makes a statement under paragraph (37) or paragraph (38) of this subsection without having reasonable grounds for the opinion expressed in the statement violates this chapter and may be removed by order of the Commissioner.

(40) If a protected cell captive insurer is liable for any penalty, under this chapter or otherwise, due to an act or failure to act of a protected cell of the protected cell captive insurer or of an officer or director of a protected cell of the protected cell captive insurer, the penalty shall:

(A) Only be met by the protected cell captive insurer from the cell assets of the protected cell; and

(B) Not be enforceable in any way against any other assets of the protected cell captive insurer or assets of any other protected cell.

(41) The directors of a protected cell captive insurer shall establish and maintain, or cause to be established and maintained, procedures:

(A) To segregate cell assets and liabilities separate and separately identifiable from general assets and liabilities;

(B) To segregate cell assets and liabilities of each protected cell separate and separately identifiable from cell assets and liabilities of any other protected cell; and

(C) Where relevant, to apportion or transfer assets and liabilities between protected cells or between protected cells and general assets and liabilities of the protected cell captive insurer.

(42) If a protected cell captive insurer enters into an agreement with respect to a protected cell of the protected cell captive insurer, a director shall ensure that:

(A) The other party to the transaction knows, or ought reasonably to know, that the protected cell captive insurer is acting with respect to a particular protected cell; and

(B) The minutes of any meeting of directors held with regard to the agreement clearly record the fact that the company was entering into the agreement with respect to the protected cell and that the obligation imposed by subparagraph (A) of this paragraph was, or will be, complied with.

(43) The duties of a director of a protected cell captive insurer under this chapter shall be in addition to, and not in lieu of, those under other applicable law.

(44) Any act, matter, deed, agreement, contract, instrument under seal, or other instrument or arrangement which is to be binding on or to inure to the benefit of a protected cell that is not an incorporated protected cell shall be executed by the protected cell captive insurer for and on behalf of the protected cell, shall be identified, and, if in writing, shall indicate that the execution is in the name of, by, or for the account of the protected cell.

(45) If a protected cell captive insurer fails to comply with paragraph (41) of this subsection:

(A) The directors of the protected cell captive insurer shall, notwithstanding any provisions to the contrary in the protected cell's organizational documents or in any contract with the protected cell captive insurer or otherwise, shall be personally liable for the liabilities of the protected cell captive insurer and the protected cell under the chapter, matter, deed, agreement, contract, instrument or arrangement that was executed; and

(B)(i) Unless they were fraudulent, reckless, negligent, or acted in bad faith, the directors of the protected cell captive insurer shall have a right of indemnity, in the case of a matter on behalf of or attributable to a protected cell, against the assets of the protected cell.

(ii) In the case of a matter not on behalf of or attributable to a protected cell, the directors shall have a right of indemnity against the general assets of the protected cell captive insurer.

(46) Notwithstanding the provisions of paragraph (45)(A) of this subsection, a court may relieve a director of all or part of the personal liability under paragraph (45) of this subsection if he or she satisfies the court that he or she should be relieved because:

(A) The director was not aware of the circumstances giving rise to the liability and, in being not so aware, was not fraudulent, reckless, or negligent and did not act in bad faith; or

(B) The director expressly objected, and exercised such rights as a director, whether by way of voting power or otherwise, so as to try to prevent the circumstances giving rise to the liability.

(47) If, pursuant to the provisions of paragraph (46) of this subsection, the court relieves a director of all or part of his or her personal liability under paragraph (45)(A) of this subsection, the court may order that the liability in question shall instead be met from such of the protected cell or general assets of the account of the protected cell captive insurer as may be specified in the order.

(48) Any provision in the organizational document of a captive insurer or any other contractual provision under which the protected cell captive insurer may be liable, which provision purports to indemnify directors in respect of conduct which would otherwise prohibit them from indemnification by virtue of paragraph (46) of this subsection, shall be void.

(49) A captive insurer may amend its organizational document to become a protected cell captive insurer.

(50) The amendment of the organizational document of a captive insurer to become a protected cell captive insurer shall require approval by:

(A) Holders of $\frac{2}{3}$ of the outstanding shares or ownership interests of the captive insurer, unless a greater amount is required by the organizational document of the captive insurer; and

(B) All the creditors of the captive insurer; provided, that if the consent of all the creditors of the captive insurer cannot be obtained, the amendment may be approved by the Commissioner if he or she is satisfied that no creditor will be materially prejudiced by the amendment.

(51) A protected cell captive insurer may amend its other organizational document to cease to be a protected cell captive insurer.

(52) The amendment of the other organizational document of a captive insurer to cease to be a protected cell captive insurer shall require approval by:

(A) The Commissioner;

(B) Holders of $\frac{2}{3}$ of the outstanding shares or ownership interests of the protected cell captive insurer, unless a greater amount is required by the other organizational document of the protected cell captive insurer;

(C) Two-thirds of the participants of each protected cell; and

(D) All the creditors of the protected cell captive insurer and its protected cells; provided, that if the consent of all the creditors of the captive insurer and its protected cells cannot be obtained, the amendment may be approved by the Commissioner upon being satisfied that no creditor will be materially prejudiced by the amendment.

(53) If a captive insurer or protected cell captive insurer seeks to change its status in accordance with paragraph (49) or (51) of this subsection, the Commissioner shall issue a certificate of authority that is appropriate to the amended status of the company if there is delivered to the Commissioner:

(A) A copy of the amendment to its name; and

(B) Evidence satisfactory to the Commissioner that the requirements of paragraph (50) or (52) of this subsection have been met.

(54) If a company changes its status in accordance with this section, the

change of status shall take effect when the Commissioner issues a new certificate of authority.

(55) A protected cell of a protected cell captive insurer may be transferred to another protected cell captive insurer.

(56) The protected cell captive insurers between which a protected cell is being transferred shall enter into a written agreement that sets forth the terms of the transfer.

(57) A transfer of a protected cell shall be approved when the directors of each protected cell captive insurer who authorized the transfer have approved the transfer and:

(A) When the transfer agreement is approved by the Commissioner as an arrangement in accordance with this chapter;

(B) When the transfer agreement is consented to by at least $\frac{2}{3}$ of the participants of the protected cell being transferred and all the creditors, if any, of that protected cell; or

(C) If the agreement of all the creditors of the cell cannot be obtained, when the transfer is approved by the Commissioner upon being satisfied that no creditor of the cell will be materially prejudiced by the transfer.

(58) Within 30 days of a transfer agreement being approved by the Commissioner, the protected cell captive insurer to which the protected cell is being transferred shall deliver to the Commissioner:

(A) A copy of the executed transfer agreement; and

(B) A declaration made in accordance with paragraph (59) of this subsection, signed by a majority of the directors of the protected cell captive insurer transferring the protected cell who authorized the transfer.

(59) The declaration required in paragraph (58)(B) of this subsection shall state that each director has reason to believe that:

(A) The protected cell being transferred is able to discharge its liabilities as they become due;

(B) There are no creditors of the protected cell captive insurer from which the cell is being transferred whose interests will be unfairly prejudiced by the transfer; and

(C) The transfer agreement has been approved in accordance with this chapter.

(60) If a protected cell captive insurer fails to deliver the documents mentioned in paragraph (58) of this subsection within the 30-day period, the Commissioner may void the transfer.

(61) The Commissioner may void the transfer and order the removal of any director who makes a declaration under paragraph (59) of this subsection without having the grounds to do so.

(62) Upon delivery of the documents referred to in paragraph (58) to the Commissioner, the Commissioner shall, if those documents comply with this chapter:

(A) Record the transfer of the protected cell;

(B) Issue to the protected cell a new certificate of authority; and

(C) Record that the protected cell has ceased to be a protected cell of the protected cell captive insurer that transferred the protected cell.

(63) Upon the issuance of the new certificate of authority:

(A) The protected cell shall cease to be a protected cell of the protected cell captive insurer that transferred it;

(B) The protected cell becomes a protected cell of the protected cell captive insurer to which it has been transferred;

(C) If a protected cell was an incorporated protected cell or an unincorporated protected cell;

(i) All property and rights to which the protected cell was entitled immediately before the issue of the new certificate of authority shall remain the property and rights of the protected cell;

(ii) The liabilities, and all contracts, debts, and other obligations to which the protected cell was subject immediately before the issue of the new certificate of authority, shall remain the liabilities, contracts, debts, and other obligations of the protected cell; and

(iii) All actions and other legal proceedings which, immediately before the issue of the new certificate of authority were pending by or against such protected cell may be continued by or against the protected cell.

(64) The operation of paragraph (63) of this subsection shall not be regarded as:

(A) A breach of contract or otherwise as a civil wrong;

(B) A breach of any contractual provision prohibiting, restricting, or regulating the assignment or transfer of rights or liabilities; or

(C) Giving rise to any remedy by a party to a contract or other instrument as an event of default under any contract or other instrument or as causing or permitting the termination of any contract or other instrument or of any obligation or relationship.

(65) A protected cell shall not be transferred under this chapter if the transfer would be inconsistent with the articles of incorporation or similar organizational document, if applicable, of the protected cell, the protected cell captive insurer transferring the protected cell, or the protected cell captive insurer to which it is to be transferred.

(66) Any insurer, including a captive insurer, that is not a protected cell captive insurer, may become a protected cell of a protected cell captive insurer.

(67) A protected cell of a protected cell captive insurer may apply to the Commissioner to be incorporated as an insurer, including a captive insurer, independent from the protected cell captive insurer.

(68) An application made under paragraph (67) of this subsection shall be approved by $\frac{2}{3}$ of the participants of the protected cell or, if the protected cell has more than one class of participants, $\frac{2}{3}$ approval of each class of participants, unless the organizational document of the protected cell provides for a greater percentage.

(69) If a protected cell has made an application under paragraph (68) of this subsection, a participant of the protected cell who objects to the protected cell being incorporated as an insurer, including a captive, independent of its protective cell captive may petition the Commissioner for an order denying the application on the grounds that the incorporation or the terms of the incorporation unfairly prejudice his or her interests.

(70) An application shall not be made under paragraph (69) of this subsection after the expiration of the 30-day period following the application being made under paragraph (67) of this subsection.

(71) If a protected cell is licensed as a legal entity pursuant to this section, and if the protected cell was either an incorporated protected cell or an unincorporated protected cell of a protected cell captive insurer:

(A) All property and rights to which the protected cell was entitled immediately before its licensure as a new entity shall remain the property and rights of the new entity;

(B) The protected cell shall remain subject to all criminal and civil liabilities and all contracts, debts, and other obligations to which the protected cell was subject immediately before its licensure as a new entity;

(C) All contracts, debts, and other obligations of the protected cell shall remain the contracts, debts, other obligations of the new entity; and

(D) All actions and other legal proceedings which, immediately before the licensure of the protected cell as a new entity, were pending by or against the protected cell may be continued by or against the new entity.

(72) The operation of paragraph (71)(B) and (D) of this subsection shall not be regarded as:

(A) A breach of contract;

(B) A breach of any contractual provision prohibiting, restricting, or regulating the assignment or transfer of rights or liabilities; or

(C) Giving rise to any remedy by a party to a contract or other instrument as an event of default under the contract or other instrument or as causing or permitting the termination of any contract or other instrument or of any obligation or relationship.

(Mar. 17, 2005, D.C. Law 15-262, § 5, 52 DCR 1205; Mar. 14, 2007, D.C. Law 16-286, § 2, 54 DCR 957; Mar. 25, 2009, D.C. Law 17-353, § 166, 56 DCR 1117.)

Effect of amendments. — D.C. Law 16-286 rewrote this section, which formerly read:

“(a) A captive insurer may form one or more segregated accounts to insure risks of one or more participants.

“(b) A captive insurer that maintains a segregated account shall, at the time of paying the annual fee, pay an additional annual fee in an amount to be established by the Commissioner for each segregated account.

“(c) A captive insurer may create one or more segregated accounts to segregate its assets and liabilities from the assets and liabilities of its segregated accounts. The assets and liabilities of each segregated account shall be held separately from the assets and liabilities of all other segregated accounts.

“(d) A captive insurer shall be a single legal entity and each segregated account of or within a captive insurer may be established as a separate legal entity, which shall constitute a legal entity separate from the captive insurer. Each segregated account shall be separately

identified or designated as being a part of the captive insurer.

“(e) A captive insurer may create and issue shares in one or more classes or series for one or more segregated accounts. The proceeds of the issue shall be included in the assets of the segregated account that issued the shares.

“(f) The proceeds of the issue of shares, other than segregated account shares, shall be included in the captive insurer’s general assets.

“(g) A captive insurer may pay a dividend on segregated account shares of any class or series whether or not a dividend is declared on any other class or series of segregated account shares, or any other shares.

“(h) Segregated account dividends may be paid on the segregated account shares from the segregated account assets. The dividends shall only be paid to the shareholders of the segregated account from which the segregated account shares were issued and otherwise in accordance with the rights of the shares.

“(i) Any act, matter, deed, agreement, con-

tract, instrument under seal, or other instrument or arrangement which is to be binding on or to inure to the benefit of a segregated account or accounts shall be executed by the captive insurer for and on behalf of such segregated account or accounts, shall be identified, and, if in writing, shall indicate that the execution is in the name of, or by or for the account of, the segregated account or accounts.

“(j) If a captive insurer is in breach of subsection (i) of this section:

“(1) The directors of the captive insurer shall, notwithstanding any provisions to the contrary in the captive insurer’s organizational documents or in any contract with the company or otherwise, incur personal liability for the liabilities of the captive insurer and the segregated account under this chapter, matter, deed, agreement, contract, instrument, or arrangement that was executed; and

“(2) Unless they were fraudulent, reckless, negligent, or acted in bad faith, the directors of the captive insurer shall have a right of indemnity:

“(A) In the case of a matter on behalf of or attributable to a segregated account or accounts; against the assets of that account or accounts.

“(B) In the case of a matter not on behalf of or attributable to any segregated account or accounts, against the general assets of the captive insurer.

“(k) Notwithstanding the provisions of subsection (j)(1) of this section, a court may relieve a director of all or part of this personal liability thereunder if he or she satisfies the court that he or she should be relieved because:

“(1) The director was not aware of the circumstances giving rise to the liability and, in being not so aware, the director was not fraudulent, reckless, or negligent, and did not act in bad faith; or

“(2) The director expressly objected, and exercised his or her rights as a director, whether by way of voting power or otherwise, so as to try to prevent the circumstances giving rise to the liability.

“(l) If, pursuant to the provisions of subsection (k) of this section, the court relieves a director of all or part of his or her personal liability under subsection (j)(1) of this section, the court may order that the liability in question shall instead be met from such of the segregated account or general assets of the account of the captive insurer as may be specified in the order.

“(m) Any provision in the organizational documents of a captive insurer, or any other contractual provision under which the captive insurer may be liable, which purports to indemnify directors in respect of conduct which would otherwise disentitle them to an indem-

nity by virtue of subsection (j)(2) of this section, shall be void.

“(n) The assets of a captive insurer shall be either segregated account assets or general assets. The segregated account assets shall comprise the assets of the captive insurer held within or on behalf of the segregated accounts of the captive insurer. The general assets of a captive insurer shall comprise the assets of the captive insurer which are not segregated account assets.

“(o) The assets of a segregated account are comprised of assets representing the capital stock and reserves attributable to the segregated account or all other assets attributable to or held within the segregated account. For the purposes of this subsection, ‘reserves’ includes retained earnings, capital surplus, and paid-in capital.

“(p) The directors of a captive insurer shall establish and maintain, or cause to be established and maintained, procedures:

“(1) To segregate, and keep segregated, account assets separate and separately identifiable from general assets;

“(2) To segregate, and keep segregated, account assets of each segregated account separate and separately identifiable from segregated account assets of any other segregated account; and

“(3) If relevant, to apportion or transfer assets and liabilities between segregated accounts, or between segregated accounts and general assets, of the segregated account captive insurer.

“(q) Segregated account assets shall:

“(1) Only be available and used to meet liabilities of the creditors with respect to that segregated account, and those creditors shall thereby be entitled to have recourse to the segregated account assets attributable to that segregated account; and

“(2) Not be available or used to meet liabilities to, and shall be absolutely protected from, the creditors of the captive insurer who are not creditors with respect to a particular segregated account, and those creditors shall not be entitled to have recourse to the protected segregated account assets.

“(r) If a liability of a captive insurer to a person arises from a matter, or is otherwise imposed, with respect to a particular segregated account, the liability shall extend only to, and that person shall, with respect to that liability, be entitled to have recourse only to:

“(1) First, the segregated account assets attributable to the segregated account; and

“(2) Second, the captive insurer’s general assets, to the extent that the segregated account assets attributable to the segregated account, are insufficient to satisfy the liability, and to the extent that the captive insurer’s

general assets exceed any minimum capital amounts lawfully required by this chapter.

“(s) If a liability of a captive insurer to a person arises otherwise than from a matter in respect of a particular segregated account or accounts, or is imposed otherwise than in respect of a particular segregated account or accounts, the liability shall extend only to, and that person shall, with respect to that liability, be entitled to have recourse only to the captive insurer’s general assets.

“(t) Liabilities of a captive insurer not attributable to any of its segregated accounts shall be discharged from the account captive insurer’s general assets. Income, receipts, and other property or rights of or acquired by a captive insurer not otherwise attributable to any segregated account shall be attributed to the captive insurer’s general assets to the extent that the captive insurer’s general assets exceed any minimum capital amounts lawfully required by this chapter.

“(u)(1) Each segregated account shall be accounted for separately on the books and records of the captive insurer to reflect the financial condition and results of operations of the segregated account, including net income or loss, dividends, or other distributions to participants, and such other factors as may be provided by the participant contract or required by the Commissioner.

“(2) No sale, exchange, or other transfer of assets shall be made by the captive insurer between or among any of its segregated accounts without the written consent of the segregated accounts and the Commissioner.

“(3) No sale, exchange, transfer of assets, dividend, or distribution shall be made from a segregated account to any person without the Commissioner’s prior written approval and the approval shall not be given if the sale, exchange, transfer, dividend, or distribution would result in the insolvency or impairment with respect to the segregated account.

“(4) Each segregated account captive insurer shall annually file with the Commissioner such financial reports as the Commissioner shall

require, which shall include financial statements detailing the financial experience of each segregated account.

“(5) Each captive insurer shall notify the Commissioner within 10 business days of any segregated account that is insolvent or otherwise unable to meet its claims or expense obligations.

“(6) No participant contract shall take effect without the Commissioner’s prior written approval. The addition of each new segregated account or the withdrawal of any participant from any existing segregated account shall constitute a change in the strategic business plan of that segregated account requiring the Commissioner’s prior written approval.

“(v) Any person or legal entity may be a participant in a segregated account formed or licensed under this chapter.

“(w) A participant in a segregated account need not be a shareholder insured within the segregated account or by the captive insurer or any affiliate thereof.”

D.C. Law 17-353 validated a previously made technical correction in subsec. (b)(41)

Emergency legislation. — For temporary (90 day) addition of section, see § 5 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-286. — Law 16-286, the “Captive Insurance Company Amendment Act of 2006”, was introduced in Council and assigned Bill No. 16-898, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28, 2006, it was assigned Act No. 16-645 and transmitted to both Houses of Congress for its review. D.C. Law 16-286 became effective on March 14, 2007.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

§ 31-3931.05. Liquidation and rehabilitation of protected cells.

(a) If a protected cell captive insurer with one or more protected cells is being liquidated under this chapter, the protected cell captive insurer shall not be deemed to have no assets and no liabilities if the protected cell captive insurer continues to have a protected cell.

(b) In the course of the liquidating the protected cell captive insurer, each protected cell shall be:

- (1) Transferred to another protected cell captive insurer;
- (2) Liquidated;

(3) Continued as a separate legal entity or protected cell under the law of another jurisdiction;

(4) Incorporated independently of the protected cell captive insurer; or

(5) Merged with another insurer.

(c) If a protected cell captive insurer is being liquidated, the liquidation shall not apply with respect to any protected cell of the protected cell captive insurer.

(d) If a protected cell of a protected cell captive insurer is being liquidated, the liquidation shall not apply with respect to the protected cell captive insurer or any other protected cell of the protected cell captive insurer.

(e) The court, on the application of a protected cell captive insurer, may determine, in accordance with this chapter, if a liability of the protected cell captive insurer shall be satisfied by its general assets, by the cell assets of a specific protected cell of the company, or by a combination of those assets.

(f) Notwithstanding any statutory provision or rule of law to the contrary, in the winding-up of a captive insurer, the liquidator shall:

(1) Deal with the captive insurer's assets only in accordance with the procedures set out in subsection (h)(6) of this section; and

(2) In the discharge of the claims of creditors of the captive insurer, shall apply the captive insurer's assets to those entitled to have recourse thereto under the provisions of § 31-3931.04.

(g)(1) A petition for a liquidation or rehabilitation order with respect to a protected cell of a protected cell captive insurer may be made by:

(A) The protected cell captive insurer;

(B) The majority of the directors of the protected cell captive insurer;

(C) Any creditor of that protected cell; or

(D) The Commissioner.

(2) Notice of a petition to the court for a liquidation or rehabilitation order with respect to a protected cell of a captive insurer shall be served upon:

(A) The captive insurer;

(B) The Commissioner; and

(C) Such other persons as the court may direct.

(h)(1) Subject to the provisions of this section, the court may make a liquidation or rehabilitation order with respect to a protected cell if, in relation to a captive insurer, the court is satisfied that:

(A) The cell assets attributable to a particular protected cell of the captive insurer, and in those cases where creditors of the captive insurer with respect to the protected cell are entitled to have recourse to the captive insurer's general assets, are, or are likely to be, insufficient to discharge the claims of creditors with respect to that protected cell; and

(B) An order would achieve the purposes set forth in paragraph (3) of this subsection.

(2) A liquidation or rehabilitation order may be made with respect to one or more protected cells.

(3) A liquidation or rehabilitation order shall direct that the business and cell assets of, or attributable to, a protected cell shall be managed by a liquidator or rehabilitator specified in the order for the purpose of:

(A) The orderly closing or rehabilitation of the business of, or attributable to, the protected cell; and

(B) The distribution of the cell assets, or assets attributable to the protected cell, to those having recourse thereto.

(i) The liquidator or rehabilitator of a protected cell:

(1) Shall have all the functions and powers of the directors responsible for the business and cell assets of, or attributable to, the protected cell;

(2) May at any time apply to the court for directions as to the extent or exercise of any function or power, for the liquidation or rehabilitation order to be discharged or varied, or for an order as to any matter occurring during the course of the liquidation or rehabilitation.

(3) In exercising his functions and powers, shall act as the agent of the captive insurer and shall not incur personal liability except to the extent that he or she acts fraudulently, recklessly, negligently, or in bad faith.

(j) Upon the filing of a petition for, and during the period of operation of, a liquidation or rehabilitation order:

(1) No proceedings shall be instituted or continued by or against the captive insurer or protected cell in respect of which the liquidation or rehabilitation order was made; and

(2) No action shall be taken to enforce any security or in the execution of legal process with respect to the business or cell assets of or attributable to the protected cell with respect to which the liquidation or rehabilitation order was made, except by leave of the court.

(k) During the period of operation of a liquidation or rehabilitation order:

(1) The functions and powers of the directors shall cease with respect to the business of, or attributable to, the protected cell or cell assets for which the order was made; and

(2)(A) The liquidator or rehabilitator of the protected cell shall be entitled to be present at all meetings of the captive insurer or protected cell and to vote at such meetings as if he or she were a director of the captive insurer.

(B) Unless there are no creditors that are entitled to have recourse to the captive insurer's general assets, the liquidator's or rehabilitator's voting authority shall include matters concerning the captive insurer's general assets.

(l)(1) The court shall not discharge a liquidation or rehabilitation order issued pursuant to this section unless it appears to the court that the purpose for which the order was made has been achieved, substantially achieved, or is incapable of being achieved.

(2) The court, on hearing a petition for the discharge or variation of a liquidation or rehabilitation order, may make any interim order or adjourn the proceeding.

(3) Upon the court issuing an order discharging a liquidation or rehabilitation order for a protected cell on the ground that the purpose for which the order was made had been achieved or substantially achieved, the court may direct that any payment made by the liquidator or rehabilitator to any creditor of the captive insurer, with respect to that protected cell, shall be deemed full satisfaction of the liabilities of the captive insurer to the creditor with respect

to the protected cell, and the creditor's claims against the captive insurer with respect to that protected cell shall be of its administrative, regulatory, and marketing activities as prescribed by law.

(Mar. 17, 2005, D.C. Law 15-262, § 6, 52 DCR 1205; Mar. 14, 2007, D.C. Law 16-286, § 2, 54 DCR 957.)

Effect of amendments. — D.C. Law 16-286 rewrote this section, which formerly read:

"(a) Notwithstanding any statutory provision or rule of law to the contrary, in the winding-up of a captive insurer, the liquidator:

"(1) Shall deal with the company's assets only in accordance with the procedures set forth in subsection (c)(6) of this section; and

"(2) In the discharge of the claims of creditors of the captive insurer, shall apply the captive insurer's assets to those entitled to have recourse thereto under the provisions of § 31-3931.04.

"(b)(1) A petition for a liquidation or rehabilitation order with respect to a segregated account of a captive insurer may be made by:

"(A) The segregated account captive insurer;

"(B) The majority of the directors of the segregated account captive insurer;

"(C) Any creditor of the segregated account; or

"(D) The Commissioner.

"(2) Notice of a petition to the court for a liquidation or rehabilitation order with respect to a segregated account of a captive insurer shall be served upon:

"(A) The captive insurer;

"(B) The Commissioner; and

"(C) Such other persons as the court may direct.

"(c)(1) Subject to the provisions of this section, the court may make a liquidation or rehabilitation order with respect to a segregated account if, in relation to a captive insurer, the court is satisfied that the:

"(A) Segregated account assets attributable to a particular segregated account of the captive insurer, and in those cases where creditors of the captive insurer with respect to that segregated account are entitled to have recourse to the captive insurer's general assets, are or are likely to be insufficient to discharge the claims of creditors with respect to that segregated account; and

"(B) Making of an order under this section would achieve the purposes set forth in paragraph (3) of this subsection.

"(2) A liquidation or rehabilitation order may be made with respect to one or more segregated accounts.

"(3) A liquidation or rehabilitation order shall direct that the business and segregated account assets of, or attributable to, a segregated account shall be managed by a liquidator or

rehabilitator specified in the order for the purpose of:

"(A) The orderly closing or rehabilitation of the business of, or attributable to, the segregated account; and

"(B) The distribution of the segregated account assets, or assets attributable to the segregated account, to those having recourse thereto.

"(d) The liquidator or rehabilitator of a segregated account:

"(1) Shall have all the functions and powers of the directors responsible for the business and segregated account assets of, or attributable to, the segregated account;

"(2) May at any time apply to the court for directions as to the extent or exercise of any function or power, for the liquidation or rehabilitation order to be discharged or varied, or for an order as to any matter occurring during the course of the liquidation or rehabilitation; and

"(3) In exercising his functions and powers, shall be deemed to act as the agent of the captive insurer and shall not incur personal liability except to the extent that he acts fraudulently, recklessly, negligently, or in bad faith.

"(e) Upon the filing of a petition for, and during the period of operation of, a liquidation or rehabilitation order:

"(1) No proceedings shall be instituted or continued by or against the captive insurer or segregated account in respect of which the liquidation or rehabilitation order was made; and

"(2) No steps shall be taken to enforce any security or in the execution of legal process in respect of the business or segregated account assets of or attributable to the segregated account in respect of which the liquidation or rehabilitation order was made, except by leave of the court.

"(f)(1) During the period of operation of a liquidation or rehabilitation order:

"(A) The functions and powers of the directors shall cease with respect to the business of, or attributable to, the segregated account or segregated account assets for which the order was made; and

"(B) The liquidator or rehabilitator of the segregated account shall be entitled to be present at all meetings of the captive insurer or segregated account and to vote at such meetings as if he or she were a director of the captive insurer.

“(2) Unless there are no creditors that are entitled to have recourse to the captive insurer’s general assets, the liquidator’s or rehabilitator’s voting authority includes matters concerning the captive insurer’s general assets.

“(g)(1) The Court shall not discharge a liquidation or rehabilitation order issued pursuant to this section unless it appears to the Court that the purpose for which the order was made has been achieved, substantially achieved, or is incapable of being achieved.

“(2) The Court, on hearing a petition for the discharge or variation of a liquidation or rehabilitation order, may make any interim order or adjourn the proceeding.

“(3) Upon the Court issuing an order discharging a liquidation or rehabilitation order for a segregated account on the ground that the purpose for which the order was made had been

achieved or substantially achieved, the Court may direct that any payment made by the liquidator or rehabilitator to any creditor of the captive insurer, with respect to that segregated account, shall be full satisfaction of the liabilities of the captive insurer to that creditor with respect to that segregated account, and the creditor’s claims against the captive insurer with respect to that segregated account shall be thereby extinguished.”

Emergency legislation. — For temporary (90 day) addition of section, see § 6 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-286. — For Law 16-286, see notes following § 31-3931.04.

§ 31-3931.06. Capital and surplus.

(a) In addition to any other capital required to be maintained pursuant to subsection (c) of this section, a captive insurer, authorized to do business in the District, shall at all times maintain a minimum unimpaired capital of \$100,000.

(b) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the capital required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(c) The Commissioner may require a captive insurer, including each segregated account, to maintain additional unimpaired capital based on the type, volume, and nature of the insurance business that is transacted by the captive insurer and may determine the amount of capital, if any, that may be in the form of an irrevocable letter of credit.

(d) A letter of credit used by a captive insurer or segregated account as evidence of capital required pursuant to this section shall:

(1) Be issued by a bank chartered in the District or by a branch of a bank located in the District if such bank is a member of the United States Federal Reserve System, or its deposits are insured by the Federal Deposit Insurance Corporation;

(2) Be issued on a form approved by the Commissioner; and

(3) Include a provision pursuant to which a letter of credit is automatically renewed each year.

(e) The Commissioner may approve an ongoing plan for the payment of dividends or other distributions by a captive insurer or segregated account if, at the time of each payment or distribution, the amount of capital and surplus retained by the captive insurer or segregated account is in excess of the amounts required by the Commissioner. The Commissioner shall adopt by rule:

(1) A specific amount that a captive insurer or segregated account must have in excess capital and surplus for the approval of an ongoing plan for the payment of dividends or other distributions; or

(2) A formula pursuant to which the specific amount of required excess capital and surplus may be calculated.

(f) A captive insurer shall not be issued a certificate of authority, and shall not hold a certificate of authority, unless the captive insurer has and maintains, in addition to any other surplus required to be maintained pursuant to subsection (h) of this section, an unencumbered surplus of:

(1) For a pure captive insurer, not less than \$150,000;

(2) For an association captive insurer incorporated as a stock insurer, not less than \$300,000;

(3) For an agency captive insurer, not less than \$300,000;

(4) For a rental captive insurer, not less than \$300,000;

(5) For an association captive insurer incorporated as a mutual insurer or reciprocal insurer, not less than \$500,000; and

(6) For each segregated account, not less than an amount to be established by the Commissioner.

(g) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the surplus required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(h) The Commissioner may prescribe additional requirements relating to surplus based on the type, volume, and nature of the insurance business that is transacted by a captive insurer or segregated account and requirements regarding which surplus, if any, may be in the form of an irrevocable letter of credit.

(i) A letter of credit used by a captive insurer or a segregated account as evidence of surplus required pursuant to this section shall meet the same requirements as a letter of credit issued for paid-in capital found subsection (d) of this section.

(j) The parent of a branch captive insurer shall be subject to the jurisdiction of the United States District Court for the District of Columbia for all matters involving the branch captive insurer.

(k) Except as otherwise provided in this section, a captive insurer or segregated account shall pay dividends out of, or make any other distribution from, its capital or surplus, or both, in accordance with the provisions set forth in subsection (e) of this section. A captive insurer or segregated account shall not pay dividends out of, or make any other distribution out of, its capital or surplus or both, in violation of this section unless the captive insurer or segregated account has obtained the prior written approval of the Commissioner to make the a payment or distribution.

(l) Section 31-2502.12 shall apply to risk retention groups licensed as captive insurers. A risk retention group subject to this section may petition the Commissioner for a waiver of the limitation on exposure to risks or hazards. The Commissioner may issues rules, pursuant to § 31-3931.21, establishing the circumstances under which a risk retention group may obtain, and the conditions a risk retention group shall satisfy to obtain, a waiver of the limitation.

(Mar. 17, 2005, D.C. Law 15-262, § 7, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19-103, § 2(b), 59 DCR 432.)

Effect of amendments. — D.C. Law 19-103 added subsec. (l).

Emergency legislation. — For temporary (90 day) addition of section, see § 7 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 19-103. — For history of Law 19-103, see notes under § 31-3931.03.

§ 31-3931.07. Investments.

(a) A captive insurer shall file with the Commissioner a schedule of its proposed investments, and any material changes thereto, which the Commissioner may approve if he or she determines that the investments do not threaten the solvency or liquidity of the captive insurer. The Commissioner shall not unreasonably disapprove the investments.

(b) A captive insurer or segregated account may make a loan to its parent or affiliated company if the loan:

(1) Is first approved in writing by the Commissioner;

(2) Is evidenced by a note that is in a form that is approved by the Commissioner; and

(3) Does not include any money that has been set aside as capital or surplus as required by § 31-3931.06(a) or (f).

(c) Notwithstanding subsection (b) of this section, a risk retention group licensed as a captive insurer shall be subject to subchapters I, III, and V of Chapter 13A of this title [§§ 31-1371.01 through 31-1371.07, 31-1373.01 through 31-1373.12, and 31-1375.01].

(Mar. 17, 2005, D.C. Law 15-262, § 8, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19-103, § 2(c), 59 DCR 432.)

Effect of amendments. — D.C. Law 19-103 added subsec. (c).

Emergency legislation. — For temporary (90 day) addition of section, see § 8 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 19-103. — For history of Law 19-103, see notes under § 31-3931.03.

§ 31-3931.08. Reinsurance.

(a) A captive insurer or segregated account may provide reinsurance on risks ceded by any other insurer, captive insurer, or segregated account.

(b) A captive insurer or segregated account may take credit for the reinsurance of risks or portions of risks ceded to reinsurers in compliance with Chapter 5 of this title. Prior approval of the Commissioner shall be required for ceding or taking credit for the reinsurance of risks or portions of risks ceded to reinsurers not complying with Chapter 5 of this title, except for business written by an alien captive insurer outside of the United States.

(c) In addition to reinsurers authorized under Chapter 5 of this title, a captive insurer or segregated account may take credit for the reinsurance of risks or portions of risks ceded to a pool, exchange, or association acting as a reinsurer which has been authorized by the Commissioner. The Commissioner

may require any other documents, financial information, or other evidence that the pool, exchange, or association will be able to provide adequate security for its financial obligations. The Commissioner may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange, or association that, in the Commissioner's judgment, are necessary and proper to provide adequate security for the ceding captive insurer or segregated account and for the protection and consequent benefit of the public at large.

(d) For all purposes of this chapter, insurance written by a captive insurer or segregated account of any workers' compensation qualified self-insured plan of its parent or affiliates shall be deemed to be reinsurance.

(Mar. 17, 2005, D.C. Law 15-262, § 9, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 9 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.09. Application requirements.

(a) A captive insurer shall apply to the Commissioner for a certificate of authority. If one or more segregated accounts are established as separate legal entities, each segregated account shall apply for a certificate of authority. The application shall include:

(1) A proposed copy of the organizational documents of the captive insurer if the captive insurer has not been organized, or a certified copy of the organizational documents and evidence of good standing if the captive insurer has been organized;

(2) A pro forma financial statement for the captive insurer that has been prepared by a certified public accountant; and

(3) Any other statements or documents that the Commissioner requires to be filed with the application.

(b) A captive insurer shall include in its application for a certificate of authority evidence of:

(1) The amount of liquidity of its assets relative to the risks to be assumed by the captive insurer;

(2) The expertise, experience, and character of the persons who will manage the captive insurer;

(3) The overall soundness of the plan of operation of the captive insurer;

(4) The adequacy of the programs that the captive insurer is providing for loss prevention by its parent or member organizations, as applicable;

(5) Minimum capital and surplus requirements as set forth in § 31-3931.05(a) and (f) [apparently intended to be a reference to § 31-3931.09(a) and (f)]; and

(6) Such other information considered to be relevant by the Commissioner in ascertaining whether the proposed captive insurer will be able to meet its policy obligations.

(c) An application by a captive insurer or segregated account for a certificate of authority shall include a nonrefundable application fee to be determined by

the Commissioner. The Commissioner may require the applicant to retain independent legal, financial, and examination services from outside the Department to review and make recommendations regarding the applicant's qualifications, and to submit those reports and recommendations to the Commissioner for his or her review. The cost of those services shall be paid by the applicant.

(d) If the Commissioner determines that the documents and statements filed by the captive insurer or segregated account of a captive insurer are complete and satisfy the requirements for a certificate of authority, the Commissioner shall issue a certificate of authority to the captive insurer or segregated account within 30 days. Each certificate shall be renewed each year not later than the 30th day of April succeeding the date of its issuance. The Commissioner may impose an administrative fine or penalty on a captive insurer or segregated account that fails to renew its certificate of authority before August 1. The Commissioner may suspend or revoke the certificate of authority of a captive insurer or segregated account that fails to renew its certificate of authority on or after August 1.

(e) A captive insurer shall pay a fee to be established by the Commissioner for the issuance of a certificate of authority and an annual fee to be established by the Commissioner for the renewal of its certificate of authority. A captive insurer may be required to pay a fee for one or more segregated accounts.

(f) A captive insurer shall include its strategic business plan with its application for the issuance of its certificate of authority. If the captive insurer intends to make any material or substantive changes to its strategic business plan, the captive insurer shall file a copy of the amended strategic business plan with the Commissioner for prior written approval.

(Mar. 17, 2005, D.C. Law 15-262, § 10, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 10 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.10. Name.

A captive insurer shall not use or adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for any other insurer licensed in the District.

(Mar. 17, 2005, D.C. Law 15-262, § 11, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 11 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.11. Requirements for transacting business.

(a) A captive insurer shall not transact business in the District unless the

captive insurer and, if applicable, each segregated account of a captive insurer, first obtains a certificate of authority from the Commissioner.

(b) In determining whether to grant the approval required in subsection (a) of this section, the Commissioner shall consider:

(1) The character, reputation, financial standing, and purposes of the incorporators or organizers;

(2) The character, reputation, financial responsibility, experience relating to insurance, and business qualifications of the officers and directors (or equivalent managers if other than a corporation) of the captive insurer;

(3) The competence of any person who, pursuant to a contract with the captive insurer, will manage the affairs of the captive insurer;

(4) The competence, reputation, and experience of the legal counsel of the captive insurer relating to the regulation of insurance;

(5) If the captive insurer is a rental captive insurer, the competence, reputation and experience of the underwriter of the captive insurer;

(6) The strategic business plan of the insurer; and

(7) Such other aspects of the captive insurer as the Commissioner considers advisable.

(c) A captive insurer shall:

(1) Maintain an office in the District;

(2)(A) Appoint a person in the District of Columbia, consistent with the requirements of § 31-202(b), as the agent for service of process and to otherwise act on behalf of the captive insurer in the District.

(B) If the registered agent cannot be located with reasonable diligence for the purpose of serving notice or demand on the captive insurer, the notice or demand may be served on the Commissioner, who shall be deemed to be the agent for the captive insurer;

(3) Make adequate arrangements with a bank chartered in the District, or a branch of a bank located in the District if the bank is a member of the United States Federal Reserve System or its deposits are insured by the Federal Deposit Insurance Corporation;

(4) Employ or enter into a contract with an individual or business organization to manage the affairs of the captive insurer, which individual or business organization shall meet the standards of competence and experience satisfactory to the Commissioner;

(5) Employ or enter into a contract with a qualified, experienced, certified public accountant or a firm of certified public accountants, which accountant or firm shall meet the standards of competence and experience in matters concerning the regulation of insurance in the District, as determined by the Commissioner;

(6) Employ or enter into a contract with qualified, experienced actuaries to perform reviews and evaluations of the operations of the captive insurer; and

(7) Employ or enter into a contract with an attorney who is licensed to practice law in the District, which attorney shall meet the standards of competence and experience in matters concerning the regulation of insurance in the District, as determined by the Commissioner.

(d) The board of directors of a captive insurer shall meet at least one time each year in the District.

(e) Each a segregated account maintained by a captive insurer shall not have to comply with subsection (c) of this section unless the segregated account is organized as a separate legal entity.

(f) Notwithstanding subsection (a) of this section, a captive insurer that obtains a provisional certificate of authority may engage in limited activities as part of the initial organization and capitalization of the captive insurer.

(Mar. 17, 2005, D.C. Law 15-262, § 12, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 12 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.12. Tax on premiums collected.

(a) Except as otherwise provided in this section, a captive insurer shall pay to the District, not later than March 2 of each year, a tax at the rate of:

(1) Two hundred fifty thousandths of one percent on the first \$25 million of its net direct premiums;

(2) One hundred fifty thousandths of one percent on the next \$25 million of its net direct premiums; and

(3) Fifty thousandths of one percent on each additional dollar of its net direct premiums.

(a-1) A captive insurer organized as a risk retention group, as defined in § 31-4101(12), shall pay to the District, not later than March 2 of each year, a tax at the rate of:

(1) Thirty-eight hundredths of 1% on the first \$20 million of its total net direct premiums;

(2) Twenty-five hundredths of 1% on the next \$20 million of its total net direct premiums; and

(3) Eighteen hundredths of 1% on each additional dollar of its total net direct premiums.

(b)(1) Except as otherwise provided in this section, a captive insurer shall pay to the District, not later than March 2 of each year, a tax at the rate of:

(A) Two hundred twenty-five thousandths of one percent on the first \$25 million of revenue from assumed reinsurance premiums;

(B) One hundred fifty thousandths of one percent on the next \$25 million of revenue from assumed reinsurance premiums; and

(C) Twenty-five thousandths of one percent on each additional dollar of revenue from assumed reinsurance premiums.

(2) The tax on reinsurance premiums pursuant to this subsection shall not be levied on premiums for risks or portions of risks which are subject to taxation on a direct basis pursuant to subsection (a) of this section. A captive insurer shall not pay any reinsurance premium tax pursuant to this subsection on revenue related to the receipt of assets by the captive insurer in exchange

for the assumption of loss reserves and other liabilities of another insurer that is under common ownership and control with the captive insurer, if the transaction is part of a plan to discontinue the operation of the other insurer and the intent of the parties to the transaction is to renew or maintain such business with the captive insurer.

(c) If the sum of the taxes to be paid by a captive insurer, other than a risk retention group licensed as an association captive insurer, calculated pursuant to subsections (a) and (b) of this section is less than \$7,500 in any given year, the captive insurer shall pay a minimum tax of \$7,500 for the year.

(d) If the sum of the taxes to be paid by a risk retention group, licensed as an association captive insurer, calculated pursuant to subsections (a-1) and (b) of this section is less than \$15,000 in any given year, the captive insurer shall pay a minimum tax of \$15,000 for the year.

(e) The total tax paid by a captive insurer shall not exceed \$100,000 in any year.

(f) In the case of a branch captive insurer, the tax provided for in this section shall apply only to the branch business of the branch captive insurer.

(g) In the case of annuity business, the tax provided for in this section shall not apply.

(h) Notwithstanding any specific statute to the contrary and except as otherwise provided in this subsection, the tax provided for by this section shall constitute all the taxes collectible pursuant to the laws of the District from a captive insurer, and no occupation tax or other taxes shall be levied or collected from a captive insurer by the District, except for real property taxes pursuant to Chapter 8 of Title 47 or personal property taxes pursuant to subchapter II of Chapter 15 of Title 47.

(i) A captive insurer that is issued a certificate of authority during the last quarter of the calendar year may file a written request with the Commissioner for a reduction in the minimum premium tax obligation calculated pursuant to subsections (c) and (d) of this section. The Commissioner may grant the a [sic] request pursuant to an appropriate methodology adopted by rule.

(j) The tax provided for in this section shall be calculated on an annual basis, notwithstanding policies, contracts, insurance, or contracts of reinsurance issued on a multiyear basis. In the case of multiyear policies or contracts, the premium shall be prorated for purposes of determining the tax obligation under this section.

(k) One hundred percent of the revenues collected from the tax imposed pursuant to this section shall be credited to the account for the regulation and supervision of captive insurers created by § 31-1202(b-1).

(l) Repealed.

(Mar. 17, 2005, D.C. Law 15-262, § 13, 52 DCR 1205; Apr. 7, 2006, D.C. Law 16-91, § 102(b), 52 DCR 10637; Mar. 2, 2007, D.C. Law 16-191, § 54(c), 53 DCR 6794; Aug. 16, 2008, D.C. Law 17-219, § 2014, 55 DCR 7598.)

Effect of amendments. — D.C. Law 16-91, in subsec. (k), validated previously made technical corrections.

D.C. Law 16-191, in subsec. (k), validated a previously made technical correction.

D.C. Law 17-219 added subsec. (a-1); in

subsec. (d), substituted “subsections (a-1) and (b)” for “subsections (a) and (b)” and substituted “\$15,000” for “\$10,000”; and repealed subsec. (l), which had read as follows: “(l) In determining the amount of premium taxes payable under this section, any insurance contract entered into by a captive insurance company issued a certificate of authority pursuant to this chapter, regardless of the location of the risk or the domicile of the purchaser, shall be subject to the payment of premium taxes on that transaction to the District of Columbia; provided, that upon presentation of evidence that another jurisdiction has claimed, and the company has paid, premium taxes to that jurisdiction on the same transaction, the company may credit the amount paid to the other jurisdiction against premium taxes owed to the District of Columbia.”

Emergency legislation. — For temporary

(90 day) addition of section, see § 13 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-91. — For Law 16-91, see notes following § 31-3931.02.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Legislative history of Law 17-219. — For Law 17-219, see notes following § 31-3403.01.

Short title. — Short title: Section 2013 of D.C. Law 17-219 provided that subtitle F of title II of the act may be cited as the “Captive Insurance Company Adjustment Amendment Act of 2008”.

Editor’s notes. — Section 2015 of D.C. Law 17-219 provided that this subtitle shall apply as of January 1, 2008.

§ 31-3931.13. Annual report.

(a) On or before March 2 of each year, a captive insurer shall submit to the Commissioner, on a form prescribed by the Commissioner by regulation, a report of its financial condition, as prepared by a certified public accountant. A captive insurer shall file a consolidated report on behalf of each of its segregated accounts. A captive insurer shall use generally accepted accounting principles and include any useful or necessary modifications or adaptations thereof that have been approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, as supplemented by additional information required by the Commissioner.

(b) A pure captive insurer may apply, in writing, for authorization to file its annual report based on a fiscal year that is consistent with the fiscal year of the parent company of the pure captive insurer. If an alternative date is granted:

(1) The annual report shall be due not later than 60 days after the end of each fiscal year; and

(2) The pure captive insurer shall file on or before March 2 of each year such forms as required by the Commissioner by regulation to provide sufficient detail to support its premium tax return filed pursuant to § 31-3931.12.

(c) All risk retention groups licensed as captive insurers shall comply with Chapter 3 of this title [§ 31-301 et seq.], except that the exemption in § 31-314(a) shall not apply to risk retention groups. All risk retention groups licensed as captive insurers shall comply with the actuarial opinion filing requirements set forth in §§ 31-2502.26a and 31-2502.26b.

(Mar. 17, 2005, D.C. Law 15-262, § 14, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19-103, § 2(d), 59 DCR 432.)

Effect of amendments. — D.C. Law 19-103 added subsec. (c).

Emergency legislation. — For temporary (90 day) addition of section, see § 14 of Captive Insurance Company Emergency Act of 2004

(D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 19-103. — For

history of Law 19-103, see notes under § 31-3931.03.

§ 31-3931.14. Financial examination.

(a) The Commissioner, or his designee, may visit each captive insurer at such times as he or she considers necessary to thoroughly inspect and examine the affairs of the captive insurer or segregated account of a captive insurer to ascertain:

- (1) The financial condition of the captive insurer;
- (2) The ability of the captive insurer to fulfill its obligations; and
- (3) Whether the captive insurer has complied with the provisions of this chapter and the regulations adopted pursuant thereto.

(b) The Commissioner may require a captive insurer to retain qualified independent legal, financial, and examination services from outside the Department to conduct the examination and make recommendations to the Commissioner. The cost of the examination shall be paid by the captive insurer.

(c) Chapter 14 of this title shall apply to examinations conducted pursuant to this section.

(d) For purposes of subsection (a) of this section, segregated accounts of a captive insurer shall not be separately examined unless the Commissioner has sufficient cause to examine one or more segregated accounts.

(Mar. 17, 2005, D.C. Law 15-262, § 15, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 15 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.15. Revocation, suspension, or fine.

(a) The Commissioner may revoke or suspend the certificate of authority to transact insurance business in the District of a captive insurer which:

- (1) Has failed or refused to comply with any provision or requirement of this chapter;
- (2) Is impaired in capital or surplus;
- (3) Is insolvent;
- (4) Is determined, pursuant to Chapter 21 of this title, to be in such condition that further transaction of business by the company will be hazardous to its policyholders, creditors, or the general public;
- (5) Has failed or refused to submit any report or statement required by law or order of the Commissioner;
- (6) Has failed or refused to comply with any provision of its charter or bylaws;
- (7) Has used any method in transacting insurance business pursuant to this chapter which would be detrimental to the operation of the captive insurer or would make its condition unsound with respect to its policyholders or the general public; or

(8) Has failed otherwise to comply with the laws of the District or any jurisdiction.

(b) The Commissioner may also impose a fine not to exceed \$5,000 for each violation by a captive insurer of any of the provisions found in subsection (a) of this section.

(Mar. 17, 2005, D.C. Law 15-262, § 16, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 16 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.16. Insolvency.

(a) A captive insurer shall not join or contribute financially to any risk-sharing plan, risk pool, or insurance insolvency guaranty fund in the District. A captive insurer or its insured, its parent or an affiliated company, or any member organization of its association shall not receive any benefit from the plan, pool, or fund for claims arising out of the operations of the captive insurer.

(b) The terms and conditions set forth in Chapter 13 of this title, pertaining to insurer rehabilitation, insolvency, and receiverships, shall apply in full to captive insurance companies licensed under this chapter and shall apply to the segregated accounts of a captive insurer on an account basis. If there is a conflict between the provisions of this chapter and Chapter 13 of this title, the provisions of this chapter shall prevail.

(Mar. 17, 2005, D.C. Law 15-262, § 17, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 17 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.17. Redomestication.

(a) Any captive insurer which is licensed under laws of any jurisdiction may become a domestic captive insurer in the District by complying with all of the requirements of this chapter relative to the organization and licensing of a domestic insurer of the same type and by designating an office at a place within the District. The redomesticated captive insurer may transact business in the District and shall be subject to the authority and jurisdiction of the District.

(b) All insurance contracts which are in existence at the time any captive insurer transfers its insurance domicile to the District by merger, consolidation, or any other lawful method shall continue in full force and effect upon the transfer if the captive insurer is duly qualified to transact the same type of insurance business in the District.

(c) Every transferring insurer shall notify the Commissioner of the details of

the proposed transfer and shall file promptly any resulting amendments to application documents filed or required to be filed with the Commissioner.

(d) Any domestic captive insurer, upon the approval of the Commissioner, may transfer its domicile to any state in which it is licensed to transact business as a captive insurance company and, upon the transfer, shall cease to be a domestic insurer. The Commissioner shall approve any proposed transfer unless he or she determines the transfer is not in the best interest of the policyholders.

(Mar. 17, 2005, D.C. Law 15-262, § 18, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 18 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.18. Rating organization.

A captive insurer shall not required to join a rating organization.

(Mar. 17, 2005, D.C. Law 15-262, § 19, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 19 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.19. Captive insurance regulatory and supervision trust account.

All fees, fines, penalties, and assessments received by the Commissioner under this chapter shall be deposited in, and credited to, the account established by § 31-1202(b-1), and expended in accordance with § 31-1202(b-1).

(Mar. 17, 2005, D.C. Law 15-262, § 20, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 20 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.20. Judicial review; mandamus.

(a) Any captive insurer aggrieved by any act, determination, rule, regulation, order, or any other action taken by Commissioner pursuant to this chapter, and which was the subject of a contested case, may appeal to the District of Columbia Court of Appeals, in accordance with § 2-510.

(b) The filing of an appeal pursuant to this section shall not stay the application of any rule, regulation, order, or other action of the Commissioner to the appealing party unless the court, after giving the appealing party notice and an opportunity to be heard, determines that failure to grant the stay would

be detrimental to the interest of policyholders, shareholders, creditors, or the public.

(c) Any captive insurer aggrieved by any failure of the Commissioner to act or make a determination required by this chapter may petition the Superior Court of the District of Columbia for a writ in the nature of a mandamus or a peremptory mandamus directing the Commissioner to act or make such determination forthwith.

(Mar. 17, 2005, D.C. Law 15-262, § 21, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 21 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.21. Regulations.

The Commissioner may issue rules and regulations relating to captive insurers as are necessary to enable him or her to carry out the provisions of this chapter.

(Mar. 17, 2005, D.C. Law 15-262, § 22, 52 DCR 1205.)

Emergency legislation. — For temporary (90 day) addition of section, see § 22 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

§ 31-3931.22. Applicable laws.

(a) Except as otherwise expressly provided in this chapter, only the following laws relating to insurance shall apply to risk retention groups licensed as captive insurers:

(1) Chapter 4 of this title notwithstanding the definition of the term “licensed insurer” or “insurer” in § 31-3931.01(7)(A);

(2) Subchapter I of Chapter 7 of this title;

(3) Chapter 15 of this title; and

(4) Chapter 18 of this title.

(b) Except for §§ 31-2002(a)(2) and 31-2003(f), Chapter 20 of this title shall, effective January 1, 2012, apply to risk retention groups licensed as captive insurers; provided, that the Commissioner may waive the requirement that a risk retention group licensed as a captive insurer file a Risk Based Capital Plan under Chapter 20 of this title if the insurer is in compliance with its approved plan of operation and any additional requirements imposed by the Commissioner by rule pursuant to § 31-3931.21.

(Mar. 17, 2005, D.C. Law 15-262, § 23, 52 DCR 1205; Mar. 14, 2012, D.C. Law 19-103, § 2(e), 59 DCR 432.)

Effect of amendments. — D.C. Law 19-103 rewrote the section, which formerly read:

“Except as provided in this chapter, no law relating to the insurance industry shall apply to captive insurers other than this chapter.”

Emergency legislation. — For temporary (90 day) addition of section, see § 23 of Captive Insurance Company Emergency Act of 2004

(D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 19-103. — For history of Law 19-103, see notes under § 31-3931.03.

§ 31-3931.23. Repeal and transition provisions.

(a) Chapter 39 of this title is repealed, subject to the provisions of this section.

(b) All existing fees set forth in Chapter 39 of this title, shall remain in effect under the corresponding provisions of this chapter, and shall be applicable to segregated accounts, unless modified or repealed by rules promulgated by the Commissioner.

(c) All effective certificates of authority and all conditions imposed on the certificates of authority shall apply to the extent they would have applied under prior law.

(d) All captive insurers granted a certificate of authority as sponsored captive insurers under prior law shall comply with all of the provisions found in this chapter.

(Mar. 17, 2005, D.C. Law 15-262, § 24, 52 DCR 1205; Mar. 2, 2007, D.C. Law 16-191, § 54(d), 53 DCR 6794.)

Effect of amendments. — D.C. Law 16-191, in subsec. (b), validated a previously made technical correction.

Emergency legislation. — For temporary (90 day) addition of section, see § 24 of Captive Insurance Company Emergency Act of 2004

(D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3931.01.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Subchapter II. Special Purpose Financial Captive Insurance Companies.

§ 31-3932.01. Purpose.

This subchapter provides for the creation of special purpose financial captive insurance companies for the exclusive purpose of facilitating the securitization of one or more risks as a means of accessing alternative sources of capital and achieving the benefits of securitization. Their creation is intended to achieve greater efficiencies in structuring and executing insurance securitizations, to diversify and broaden insurers' access to sources of capital, to facilitate access for many insurers to insurance securitization and capital markets financing technology, and to further the economic development of the District of Columbia through its captive insurance program.

(Mar. 17, 2005, D.C. Law 15-262, § 201, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — Law 16-285, the “Special Purpose Financial Captive Authorization Amendment Act of 2006”, was introduced in Council and assigned Bill No. 16-897, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on Novem-

ber 14, 2006, and December 5, 2006, respectively. Signed by the Mayor on December 28, 2006, it was assigned Act No. 16-644 and transmitted to both Houses of Congress for its review. D.C. Law 16-285 became effective on March 14, 2007.

§ 31-3932.02. Definitions.

In addition to the terms defined in § 31-3931.01, for the purposes of this subchapter, the term:

(1)(A) “Control” (including the terms “controlling”, “controlled by”, and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(B) Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person, but this presumption may be rebutted by a showing that control does not exist.

(C) The fact that an SPFC exclusively provides reinsurance to a ceding insurer under an SPFC contract shall not by itself constitute common control between the SPFC and the ceding insurer.

(2) “Counterparty” means the insurer that cedes risk to an SPFC and which, unless otherwise approved by the Commissioner, is the parent or an affiliated company of the SPFC.

(3) “Fair value” means:

(A) As to cash, the amount of it; and

(B) As to an asset other than cash:

(i) The amount at which that asset could be bought or sold in a current transaction between arms-length, willing parties.

(ii) The quoted mid-market price for the asset in active markets must be used if available.

(iii) If a quoted mid-market price is not available, a value determined using the best information available considering values of similar assets and other valuation methods, such as present value of future cash flows, historical value of the same or similar assets, or comparison to values of other asset classes, the value of which have been historically related to the subject asset.

(4) “Insolvency” or “insolvent” means an inability to pay obligations when they are due, unless those obligations are the subject of a bona fide dispute.

(5) “Insurance securitization” means a package of related risk-transfer instruments, capital market offerings, and facilitating administrative agreements by which proceeds are obtained by an SPFC directly or indirectly through the issuance of securities, and which proceeds are held in trust pursuant to the provisions of this subchapter to secure the obligations of the SPFC under one or more SPFC contracts with a counterparty, where invest-

ment risk to the holders of these securities is contingent upon the obligations of the SPFC to the counterparty under the SPFC contract in accordance with the terms of the transaction.

(6) "Management" means the board of directors, managing board, or other individuals vested with overall responsibility for the management of the affairs of an SPFC, including the election and appointment of officers or other of those agents to act on behalf of the SPFC.

(7) "Organizational document" means the articles of incorporation, articles of organization, bylaws, operating agreement, or other foundational documents that establish an SPFC as a legal entity.

(8) "Permitted investments" means those investments that meet the qualifications set forth in § 31-3932.07.

(9) "Qualified United States financial institution" means a financial institution that is eligible to act as a fiduciary of a trust and is:

(A) Organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States, any state of the United States, or the District of Columbia; and

(B) Regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(10) "Securities" has the same meaning as the term "security" in § 31-5601.01(31).

(11) "SPFC" or "Special Purpose Financial Captive" means a captive insurer that is formed for the purpose of an insurance securitization and that only insures or reinsures the risks of its counterparty.

(12) "SPFC contract" means a contract between an SPFC and the counterparty pursuant to which the SPFC agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business.

(13) "SPFC securities" means securities issued by an SPFC.

(14) "Surplus note" means an unsecured subordinated debt obligation possessing characteristics consistent with paragraph 3 of the Statement of Statutory Accounting Principles No. 41, as amended, National Association of Insurance Commissioners.

(Mar. 17, 2005, D.C. Law 15-262, § 202, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.03. Application of subchapter I of this chapter.

(a) Except as otherwise provided, §§ 31-3931.03, 31-3931.04, 31-3931.05, 31-3931.09, 31-3931.10, 31-3931.11, 31-3931.12, 31-3931.13, 31-3931.14, 31-3931.15, 31-3931.16, 31-3931.17, 31-3931.18, 31-3931.19, 31-3931.20, 31-3931.21, and 31-3931.09 through 31-3931.22 shall apply under this subchapter to SPFCs.

(b) The Commissioner, by rule or order, may exempt an SPFC, on a

case-by-case basis, from the provisions of this title that the Commissioner determines to be inappropriate given the nature of the risks to be insured.

(Mar. 17, 2005, D.C. Law 15-262, § 203, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944; Mar. 25, 2009, D.C. Law 17-353, § 165(a), 56 DCR 1117.)

Effect of amendments. — D.C. Law 17-353 validated a previously made technical correction in subsec. (a).

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.04. Application requirements.

(a)(1) An SPFC shall apply to the Commissioner for a certificate of authority. The application for a certificate of authority shall include the items required by § 31-3931.09.

(2) If an SPFC will have one or more protected cells, the SPFC shall include in its application for a certificate of authority:

(A) A strategic business plan demonstrating the manner in which the SPFC will:

(i) Account for the loss and expense experience of each segregated account at a level of detail found to be sufficient by the Commissioner; and

(ii) How it will report the experience to the Commissioner;

(B) A statement acknowledging that all financial records of the SPFC, including records pertaining to any protected cells, will be made available for inspection or examination by the Commissioner;

(C) All contracts or sample contracts between the SPFC and any counterparty related to each protected cell; and

(D) Evidence that expenses are allocated to each segregated account in an equitable manner.

(b) An SPFC's strategic business plan shall include:

(1) A description of the contemplated insurance securitization, the SPFC contract, and related transactions;

(2) Draft documentation or, at the discretion of the Commissioner, a written summary of all material agreements that are entered into to effectuate the SPFC contract and the insurance securitization, which shall include the name of the counterparty, the nature of the risks being assumed, the proposed use of protected cells, if any, and the maximum amounts, purpose, and nature and the interrelationships of the various transactions required to effectuate the insurance securitization;

(3) The investment policy of the SPFC and a description of its investment strategy;

(4) A description of the underwriting, reporting, and claims payment methods by which losses covered by the SPFC contract are reported, accounted for, and settled; and

(5) Pro forma balance sheets and income statements illustrating various stress case scenarios for the performance of the SPFC under the SPFC contract.

(c) Section 31-1407, shall apply to examinations, investigations, and processing conducted pursuant to this subchapter.

(d) In determining whether to issue a certificate of authority, the Commissioner shall consider, in addition to the matters specified in § 31-3931.11(b), whether:

(1) The proposed strategic business plan provides a reasonable and expected successful operation;

(2) The terms of the SPFC contract and related transactions comply with this subchapter; and

(3) The proposed strategic business plan is not hazardous to any counterparty.

(e) The Commissioner shall not issue a certificate of authority to an SPFC until the Commissioner has received written notification, or other assurance satisfactory to the Commissioner, from the commissioner of the state of domicile of each counterparty that such commissioner has approved, or not disapproved, the transaction.

(f) The SPFC shall provide a complete set of the documentation of the insurance securitization to the Commissioner upon closing of the transactions, including an opinion of legal counsel with respect to compliance with this chapter and any other applicable laws as of the effective date of the transaction.

(g) Any material change of the SPFC's strategic business plan shall require prior approval of the Commissioner; provided, that:

(1) If initially approved in the strategic business plan, securities subsequently issued to continue the securitization activities of the SPFC either during or after expiration, redemption, or satisfaction, of part or all of the securities issued pursuant to initial insurance securitization transactions may not be considered a material change; and

(2) A change and substitution in a counterparty to a swap transaction for an existing insurance securitization as allowed pursuant to the provisions of this subchapter shall not be considered a material change if the replacement swap counterparty carries a similar or higher rating to its predecessor with 2 or more nationally recognized rating agencies.

(h) Upon termination or cancellation of an SPFC contract and the redemption of any related securities issued in connection with the SPFC contract, the certificate of authority granted by the Commissioner shall expire or, in the case of retiring and surviving protected cells, shall be modified, and the SPFC shall no longer be authorized to conduct activities unless and until a new or modified certificate of authority is issued pursuant to a new filing pursuant to the provisions of this section or as agreed by the Commissioner.

(Mar. 17, 2005, D.C. Law 15-262, § 204, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944; Mar. 25, 2009, D.C. Law 17-353, § 165(b), 56 DCR 1117.)

Effect of amendments. — D.C. Law 17-353 validated a previously made technical correction in subsecs. (d), (g) and (h).

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

§ 31-3932.05. Capital and surplus.

(a) In addition to any other capital required to be maintained pursuant to subsection (c) of this section, an SPFC authorized to do business in the District shall at all times maintain a minimum unimpaired capital of \$100,000.

(b) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the capital required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(c) The Commissioner may require an SPFC, including each protected cell, to maintain additional unimpaired capital based on the type, volume, and nature of the insurance business that is transacted by the SPFC and may determine the amount of capital, if any, that may be in the form of an irrevocable letter of credit.

(d) A letter of credit used by an SPFC or segregated account as evidence of capital required pursuant to this section shall:

(1) Be issued by a bank chartered in the District or by a branch of a bank located in the District if such bank is a member of the United States Federal Reserve System, or its deposits are insured by the Federal Deposit Insurance Corporation;

(2) Be issued on a form approved by the Commissioner; and

(3) Include a provision pursuant to which the letter of credit is automatically renewed each year.

(e) An SPFC shall not be issued a certificate of authority, and shall not hold a certificate of authority, unless the SPFC has and maintains, in addition to any other surplus required to be maintained pursuant to subsection (g) of this section, an unencumbered surplus of not less than \$150,000.

(f) Except as otherwise provided by the Commissioner pursuant to subsection (c) of this section, the surplus required to be maintained pursuant to this section shall be in the form of cash or an irrevocable letter of credit.

(g) The Commissioner may prescribe additional requirements relating to surplus based on the type, volume, and nature of the insurance business that is transacted by an SPFC or protected cell and requirements regarding which surplus, if any, may be in the form of an irrevocable letter of credit.

(h) A letter of credit used by an SPFC or segregated account as evidence of surplus required pursuant to this section shall meet the same requirements as a letter of credit issued for paid in capital found subsection (d) of this section.

(Mar. 17, 2005, D.C. Law 15-262, § 205, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.06. Securities of SPFCs.

(a) An SPFC may issue securities, including surplus notes and other forms of financial instruments, subject to and in accordance with applicable law, its approved strategic business plan, and its organizational documents.

(b) An SPFC, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of such securities.

(c) Subject to the approval of the Commissioner, an SPFC may:

(1) Account for the proceeds of surplus notes as surplus and not as debt for purposes of statutory accounting;

(2) Submit for prior approval of the Commissioner periodic written requests for payments of interest on and repayments of principal of surplus notes.

(d) Surplus notes issued by an SPFC constitute surplus or contribution notes of the type described in § 31-1340(7).

(e) The Commissioner may approve formulas for an ongoing plan of interest payments or principal repayments, or both, to provide guidance in connection with his ongoing reviews of requests to approve the payments on and principal repayments of the surplus notes.

(f) The obligation to repay principal or interest, or both, on the securities issued by the SPFC shall reflect the risk associated with the obligations of the SPFC to the counterparty under the SPFC contract.

(Mar. 17, 2005, D.C. Law 15-262, § 206, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.07. Authorized contracts.

(a) An SPFC shall insure only the risks of a counterparty and shall not issue a contract for assumption of risk or indemnification of loss other than an SPFC contract; provided, that an SPFC may cede risks assumed through an SPFC contract to third party reinsurers through the purchase of reinsurance or retrocession protection on terms approved by the Commissioner.

(b) An SPFC may enter into agreements with affiliated companies and third parties and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of an SPFC contract and insurance securitization contemplated by the strategic business plan approved by the Commissioner. The agreements may include management and administrative services agreements and other allocation and cost sharing agreements.

(c) An SPFC may enter into swap agreements, or other forms of asset management agreements, including guaranteed investment contracts, or other transactions that have the objective of leveling timing differences in funding of up-front or ongoing transaction expenses or managing asset, credit, or interest rate risk of the investments in the trust to ensure that the investments are sufficient to assure payment or repayment of the securities, and related

interest or principal payments, issued pursuant to an SPFC insurance securitization transaction or the obligations of an SPFC under an SPFC contract.

(d) An SPFC contract shall:

(1) Obligate the SPFC to indemnify the counterparty for losses;

(2) Require that contingent obligations of the SPFC under the SPFC contract that are securitized through an SPFC insurance securitization be funded and secured with assets held in trust for the benefit of the counterparty;

(3) Require the SPFC to:

(A) Enter into a trust agreement that meets the criteria set forth in this section and specifies the recoverables or reserves, or both, to covered; and

(B) Establish a trust account for the benefit of the counterparty;

(4) Stipulate that assets deposited in the trust account shall be valued according to their current fair value and shall consist only of permitted investments;

(5) Require the SPFC, before depositing assets with the trustee, to execute assignments, endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the counterparty, or the trustee upon the direction of the counterparty, may transfer whenever necessary the assets without consent or signature from the SPFC or another entity;

(6) Require that all settlements of account between the counterparty and the SPFC be made in cash or its equivalent; and

(7) Stipulate that the SPFC and the counterparty agree that the assets in the trust account, established pursuant to the provisions of the SPFC contract:

(A) May be withdrawn by the counterparty at any time, notwithstanding any other provisions in the SPFC contract; and

(B) Shall be utilized and applied by the counterparty or any successor by operation of law of the counterparty, including, subject to the provisions of § 31-3932.11, but without further limitation, any liquidator, rehabilitator, receiver, or conservator of the counterparty, without diminution because of insolvency on the part of the counterparty or the SPFC, only for the following purposes:

(i) To transfer all of the assets into one or more trust accounts for the benefit of the counterparty pursuant to and in accordance with the terms of the SPFC contract and in compliance with the provisions of this subchapter; and

(ii) To pay any other incurred and paid amounts that the counterparty claims are due pursuant to and under the terms of the SPFC contract and in compliance with this subchapter.

(e)(1) An SPFC contract may allow the SPFC to seek approval from the counterparty to withdraw from the trust all or part of the assets, or income from them, and to transfer the assets to the SPFC; provided, that,

(A) At the time of the withdrawal, the SPFC shall replace the withdrawn assets, excluding any income withdrawn, with other qualified assets having a fair value equal to the fair value of the assets withdrawn and that meet the requirements of this section; and

(B) After the withdrawals and transfer, the fair value of the assets in trust securing the obligations of the SPFC under the SPFC contract shall be no

less than the amount needed to satisfy the funded requirement of the SPFC contract.

(2) The counterparty shall be the sole judge as to the application of these provisions, but shall not unreasonably or arbitrarily withhold its approval.

(f) In fulfilling its function, an SPFC shall comply with, and, to the extent of its powers, ensure that contracts obligating other parties to perform certain functions incident to its operations are substantively and materially consistent with, the following requirements and guidelines:

(1) The assets by the SPFC shall be preserved and administered by or on behalf of the SPFC to satisfy the liabilities and obligations of the SPFC incident to the insurance securitization and other related agreements.

(2) Assets held by the SPFC in trust shall be valued at their fair value.

(3) The proceeds from the sale of securities pursuant to the insurance securitization shall be deposited with the trustee to the extent required to secure its obligations under the SPFC contract as provided by this subchapter and shall be held or invested by the trustee pursuant to the provisions of this section and the asset management agreement, if any, filed with the Department.

(4)(A) Assets of the SPFC, other than those held in trust for the counterparty, and income on trust assets received by the SPFC may be used to pay interest on, or other consideration with respect to, any securities, outstanding debt, or other obligation of the SPFC.

(B) This paragraph shall not prevent an SPFC from entering into a swap agreement or other asset management transaction that has the effect of hedging or guaranteeing the fixed or floating interest rate returns paid on the assets in trust or required for the securities issued by the SPFC generated from or other consideration or payment flows in the transaction.

(5) In the SPFC insurance securitization, the contracts or other relating documentation shall identify the SPFC.

(g) Unless otherwise approved by the Commissioner, an SPFC shall not:

(1) Issue or otherwise administer primary insurance policies;

(2) Enter into an SPFC contract with a person that is not licensed or otherwise authorized to transact the business of insurance or reinsurance in at least its state or country of domicile;

(3) Assume or retain exposure to insurance or reinsurance losses for its own account that is not funded by proceeds from an SPFC securitization that complies with the provisions of this subchapter; provided, that the SPFC may wholly or partially reinsure or retrocede the risks assumed to a third party reinsurer on terms approved by the Commissioner;

(4) Have any direct obligation to the policyholders or reinsureds of the counterparty; or

(5) Lend or otherwise invest, or place in custody, trust, or under management any of its assets with, or to borrow money or receive a loan from, other than by issuance of the securities pursuant to an insurance securitization, or advance from, anyone convicted of a felony, anyone who is untrustworthy or of known bad character, or anyone convicted of a criminal offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation, or corruption.

(Mar. 17, 2005, D.C. Law 15-262, § 207, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.08. Trust arrangements.

(a) Assets of the SPFC that are pledged to secure obligations of the SPFC to a counterparty under an SPFC contract shall be held in trust that is administered by a qualified United States financial institution. The qualified United States financial institution shall not control, be controlled by, or be under common control with, the SPFC or the counterparty.

(b) Assets of the SPFC held in trust to secure obligations under the SPFC contract shall at all times be held in:

(1) Cash and cash equivalents;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets under statutory accounting convention in its state of domicile; or

(3) Another form of security acceptable to the Commissioner.

(c) Assets of an SPFC held in trust to secure obligations under an SPFC contract shall be held by the trustee at one of the trustee's offices or branch offices in the United States and may be held in certificated or electronic form.

(d) The provisions for withdrawal by the counterparty of assets from the trust shall be clean and unconditional, subject only to the following requirements:

(1) The counterparty may withdraw assets from the trust account at any time, without notice to the SPFC, subject only to written notice to the trustee from the counterparty that funds in the amount requested are due and payable by the SPFC, pursuant to the terms of the SPFC contract.

(2) Presentment of a statement or document shall not be required to withdraw assets, except that the counterparty may be required to acknowledge receipt of withdrawn assets.

(3) The trust agreement shall indicate that it is not subject to any conditions or qualifications outside of the trust agreement.

(4) The trust agreement shall not contain references to any other agreements or documents.

(e) The trust agreement shall be established for the sole use and benefit of the counterparty at least to the full extent of the obligations of the SPFC to the counterparty under the SPFC contract. If there is more than one counterparty, a separate trust agreement shall be entered into with each counterparty and, if there more than one SPFC contract with the same counterparty, a separate trust account shall be maintained for each SPFC contract with the counterparty, in each case unless otherwise approved by the Commissioner.

(f) The trust agreement shall provide for the trustee to:

(1) Receive assets and hold all assets in a safe place;

(2) Determine that all assets are in a form that the counterparty or the trustee, upon direction by the counterparty, may transfer, whenever necessary,

the assets, without consent or signature from the SPFC or another person or entity;

(3) Furnish to the SPFC, the Commissioner, and the counterparty a statement of all assets in the trust account reported at fair value upon its inception and at intervals no less frequent than the end of each calendar quarter;

(4) Notify the SPFC and the counterparty, within 10 days, of any deposits to or withdrawals from the trust account;

(5) Upon written demand of the counterparty, immediately take the necessary steps to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the counterparty and deliver physical custody of the assets to the counterparty; and

(6) Allow no substitutions or withdrawals of assets from the trust account, except pursuant to the trust agreement or SPFC contract, or as otherwise permitted by the counterparty.

(g) The trust agreement:

(1) Shall create one or more trust accounts into which all pledged assets shall be deposited and held until distributed in accordance with the trust agreement;

(2) Shall provide that at least 30 days, but not more than 45 days, before termination of the trust account, written notification of termination shall be delivered by the trustee to the counterparty with a copy of the notice provided to the Commissioner;

(3) May be made subject to and governed by the laws of any state; provided, that the state shall be disclosed in the strategic business plan filed with and approved by the Commissioner;

(4) Shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee; and

(5) Shall provide that the trustee shall be liable for its own negligence, willful misconduct, or lack of good faith.

(h)(1) Notwithstanding the provisions of subsection (d)(3) and (4) of this section, when a trust agreement is established in conjunction with an SPFC contract, the trust agreement or SPFC contract, or both, may provide that the counterparty shall undertake to use and apply any amounts drawn upon the trust account, without diminution because of the insolvency of the counterparty or the SPFC, only for one or more of the following purposes:

(A) To pay or reimburse the counterparty for payment of the SPFC's share of premiums to be returned to owners of the counterparty's policies covered under the SPFC contract on account of cancellations of the policies under the counterparty's policies;

(B) To pay or reimburse the counterparty for payment of the SPFC's share of surrenders, benefits, losses, or other benefits covered and payable pursuant to the provisions of the SPFC contract;

(C) To fund an account with the counterparty in an amount to secure the credit or reduction from liability for reinsurance coverage provided under the SPFC contract; or

(D) To pay any other amounts the counterparty claims are due under the SPFC contract.

(2) Any assets deposited into an account of the counterparty pursuant to paragraph (1)(C) of this subsection, or withdrawn by the counterparty pursuant to subparagraph (1)(D) of this subsection, and any interest or other earnings on them, shall be held by the counterparty in trust and separate and apart from any general assets of the counterparty, for the sole purpose of funding the payments and reimbursements of the SPFC contract described in paragraph (1) of this subsection.

(3) The counterparty shall return to the SPFC:

(A) Amounts withdrawn under paragraph (1) of this subsection in excess of actual amounts required under paragraph (1)(A) through (C) of this subsection, and in excess of the amounts subsequently determined to be due under paragraph (1)(D) of this subsection;

(B) Interest at a rate not in excess of the prime rate for the amounts held pursuant to paragraph (1) of this subsection, unless a higher rate of interest has been awarded by a panel of arbitration; and

(C) Any net costs or expenses, including attorneys' fees, awarded by a panel of arbitration.

(4) If the counterparty has received notification of termination of the trust account, and if the SPFC's entire obligations secured under the specific SPFC contract remain unliquidated and undischarged 10 days before the termination date, the trust agreement shall permit the counterparty to withdraw amounts equal to the obligations and deposit the amounts in a separate account, in the name of the counterparty, in a qualified United States financial institution, separate and apart from the counterparty's general assets, to the extent the obligations or liabilities have not been funded by the SPFC, in trust only for those uses and purposes specified in paragraph (1)(A) of this subsection as may remain executory after the withdrawal and for any period after the termination date until discharged.

(Mar. 17, 2005, D.C. Law 15-262, § 208, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.09. Dividends and distributions.

(a) Dividends may be declared by the management of an SPFC if the dividends do not violate the provisions of this subchapter or jeopardize the fulfillment of the obligations of the SPFC or the trustee pursuant to the SPFC insurance securitization agreements, the SPFC contract, or any related transaction documents and other provisions of this subchapter.

(b) An SPFC shall not declare or pay dividends in any form other than in accordance with the insurance securitization transaction agreements and shall not declare or pay dividends which decrease the capital and surplus of the SPFC below \$250,000.

(c) An SPFC or protected cell of an SPFC shall not pay dividends out of, or make any other distribution out of, its capital or surplus, or both, unless the SPFC or protected cell has obtained the prior written approval of the

Commissioner to make the payment or distribution. After giving effect to the dividends, the assets of the SPFC, including assets held in trust pursuant to the terms of the insurance securitization, shall be sufficient to satisfy the Commissioner that the SPFC can meet its obligations.

(d) The Commissioner may approve an ongoing plan for the payment of dividends or other distributions by an SPFC or protected cell of an SPFC. Approval by the Commissioner of an ongoing plan for the payment of dividends or other distribution shall be conditioned upon the retention, at the time of each payment, of capital and surplus equal to or in excess of amounts specified by, or determined in accordance with formulas approved for the SPFC or protected cell by, the Commissioner.

(Mar. 17, 2005, D.C. Law 15-262, § 209, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.10. Confidentiality of examination reports; disclosure of information.

(a) Except as provided in this section, all examination reports, preliminary examination reports or results, working papers, recorded information, documents, and copies of documents produced by, obtained by, or disclosed to, the Commissioner or any other person in the course of an examination made pursuant to this section shall be confidential, shall not be subject to subpoena, and shall not be made public by the Commissioner or an employee or agent of the Commissioner without the written consent of the SPFC. This subsection shall not prevent the Commissioner from using this information in furtherance of the Commissioner's regulatory authority as provided by this subchapter. The Commissioner may grant access to this information to public officers having jurisdiction over the regulation of insurance in another state or country, or to law enforcement officers of the District or another state or agency of the federal government at any time; provided, that the officers receiving the information agree in writing to hold it in a manner consistent with this section.

(b) Information submitted pursuant to this subchapter shall be confidential and shall not be made public by the Commissioner or an agent or employee of the Commissioner without the prior written consent of the SPFC; provided, that:

(1) Information submitted pursuant to the provisions of this subchapter shall be discoverable by a party in a civil action or contested case to which the submitting SPFC is a party upon a specific finding by the court that:

(A) The SPFC is a necessary party to the action and not joined only for the purposes of evading the confidentiality provisions of this subchapter;

(B) The party seeking the information demonstrates by a clear and convincing standard that the information sought is relevant, material to, and necessary for the prosecution or defense of the claim asserted in the action; and

(C) The information sought is unavailable from other nonconfidential sources.

(2) The Commissioner may disclose the information to the public official having jurisdiction over the regulation of insurance in another state if:

(A) The public official agrees in writing to maintain the confidentiality of the information; and

(B) The laws of the state in which the public official serves require the information to be confidential.

(Mar. 17, 2005, D.C. Law 15-262, § 210, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.11. Reinsurance.

An SPFC contract which complies with this subchapter shall be granted credit for reinsurance treatment or otherwise qualifies as an asset or a reduction from liability for reinsurance ceded by a domestic insurer to an SPFC as an assuming insurer pursuant to § 31-502, for the benefit of the counterparty; provided, that:

(1) Credit shall be granted only to the extent of the fair value of the assets held in trust for, or irrevocable letters of credit issued by a bank chartered by the District or a member bank of the Federal Reserve System or as approved by the Commissioner, for the benefit of the counterparty under the SPFC contract;

(2) The assets are held in trust pursuant to this subchapter;

(3) The assets are administered in the manner and pursuant to arrangements as provided in this subchapter; and

(4) The assets are held or invested in one or more of the forms allowed by § 31-3932.07.

(Mar. 17, 2005, D.C. Law 15-262, § 211, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.12. Liquidation and rehabilitation.

(a)(1) Notwithstanding the provisions of Chapter 13 of this title, the Commissioner may apply to the Superior Court of the District of Columbia for an order authorizing the Commissioner to conserve, rehabilitate, or liquidate an SPFC domiciled in the District on one or more of the following grounds:

(A) There has been embezzlement, wrongful sequestration, dissipation, or diversion of the assets of the SPFC intended to be used to pay amounts owed to the counterparty or the holders of SPFC securities; or

(B) The SPFC is insolvent and the holders of a majority in outstanding principal amount of each class of SPFC securities request or consent to conservation, rehabilitation, or liquidation pursuant to this subchapter.

(2) The court shall not grant relief provided by paragraph (1)(A) of this

subsection unless, after notice and a hearing, the Commissioner, who shall have the burden of proof, establishes by clear and convincing evidence that relief should be granted.

(b) Notwithstanding another provision in this subchapter, rules promulgated under this subchapter, or another applicable law or rule, upon any order of conservation, rehabilitation, or liquidation of an SPFC, the receiver shall manage the assets and liabilities of the SPFC pursuant to this subchapter.

(c)(1) With respect to amounts recoverable under an SPFC contract, the amount recoverable by the receiver shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the counterparty, notwithstanding another provision in the contracts or other documentation governing the SPFC insurance securitization.

(2) Notwithstanding the provisions of Chapter 13 of this title, an application or petition, or a temporary restraining order or injunction issued pursuant to Chapter 13 of this title, with respect to a counterparty shall not prohibit the transaction of a business by an SPFC, including any payment by an SPFC made pursuant to an SPFC security, or any action or proceeding against an SPFC or its assets.

(3) Notwithstanding the provisions of Chapter 13 of this title, the commencement of a summary proceeding or other interim proceeding commenced before a formal delinquency proceeding with respect to an SPFC, and any order issued by the court, shall not prohibit:

(A) The payment by an SPFC made pursuant to an SPFC security or SPFC contract; or

(B) The SPFC from taking any action required to make the payment.

(d) Notwithstanding Chapter 13 of this title, or other laws of the District:

(1) A receiver of a counterparty shall not void a nonfraudulent transfer by a counterparty to an SPFC of money or other property made pursuant to an SPFC contract; and

(2) A receiver of an SPFC shall not void a nonfraudulent transfer by the SPFC of money or other property made to a counterparty pursuant to an SPFC contract or made to or for the benefit of any holder of an SPFC security on account of the SPFC security.

(e) With the exception of the fulfillment of the obligations under an SPFC contract, and notwithstanding another provision of this subchapter or other laws of the District, the assets of an SPFC, including assets held in trust, shall not be consolidated with or included in the estate of a counterparty in any delinquency proceeding against the counterparty pursuant to the provisions of this subchapter for any purpose, including, distribution to creditors of the counterparty.

(Mar. 17, 2005, D.C. Law 15-262, § 212, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944; Mar. 25, 2009, D.C. Law 17-353, § 165(c), 56 DCR 1117.)

Effect of amendments. — D.C. Law 17-353 validated a previously made technical correction in subsecs. (a)(1) and (c)(3).

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

§ 31-3932.13. Discount on reserves; report on reserves.

(a) An SPFC may discount its reserves at discount rates as approved by the Commissioner.

(b) An SPFC shall file annually an actuarial opinion on reserves provided by an approved independent actuary.

(Mar. 17, 2005, D.C. Law 15-262, § 213, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.14. Standards and criteria applicable in a contested case brought by a third party and certain actions by the Commissioner.

(a) A contested case brought by a third party based on a decision of the Commissioner pursuant to this subchapter shall be governed by applicable civil law; provided, that, the aggrieved party shall:

- (1) Prove the appeal through clear and convincing evidence;
- (2) Demonstrate irreparable harm;
- (3) Not have another adequate remedy at law; and

(4) Post a bond of sufficient surety to protect the interests of the holders of the SPFC securities and policyholders in an amount not less than 15% of the total amount of the securitized transaction.

(b) If the Commissioner decides to reverse, amend, or modify a certificate of authority issued to an SPFC or the order issued in connection with them for a reason other than that specified in § 31-3931.15, the Commissioner shall meet the standards and criteria provided in subsection (a) of this section.

(Mar. 17, 2005, D.C. Law 15-262, § 214, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

§ 31-3932.15. Rulemaking.

The Commissioner may promulgate rules necessary to effectuate the purposes of this subchapter. Rules promulgated pursuant to this section shall not affect an SPFC insurance securitization in effect at the time of the promulgation.

(Mar. 17, 2005, D.C. Law 15-262, § 215, as added Mar. 14, 2007, D.C. Law 16-285, § 2(b), 54 DCR 944.)

§ 31-3932.15

INSURANCE AND SECURITIES

Legislative history of Law 16-285. — For Law 16-285, see notes following § 31-3932.01.

CHAPTER 40. LIABILITY COVERAGE FOR CHILD DEVELOPMENT HOMES.

Sec.

31-4001. Definitions.

31-4002. General provisions.

Sec.

31-4003. Commissioner to establish liability coverage levels.

§ 31-4001. Definitions.

For the purposes of this chapter, the term:

(1) "Insurer" means any individual, partnership, corporation, company, organization, professional association, or other business entity that issues, amends, or renews motor vehicle liability or homeowner's liability insurance policies or contracts in the District of Columbia ("District").

(2) "Child development home" means a child development program provided in a private residence for up to a total of 5 children and infants, with no more than 2 infants in the group. The total of 5 children and infants shall not include the children of the child development home caregiver who are 6 years of age or older if the total number of children of the child development home caregiver between the ages of 6 and 15 years of age does not exceed 3 children, and of those 3 children, no more than 2 are 10 years old or younger.

(3) "Child development program" means a program responsive to the stages of physical, emotional, social, and intellectual growth and behavior of infants or children.

(4) "Caregiver" means a person whose duties include direct care, supervision, and guidance of infants or children in a child development home.

(5) "Infant" means an individual between the ages of birth and 2 years.

(6) "Child" means an individual between the ages of 2 and 15 years.

(7) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(8) "Person" means any individual, firm, partnership, company, corporation, trustee, or association.

(June 13, 1990, D.C. Law 8-140, § 2, 37 DCR 2651; May 21, 1997, D.C. Law 11-268, § 10(x), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(y), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-2501.

Effect of amendments. — D.C. Law 15-166, in par. (7), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(y) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 8-140. — Law 8-140, the "Liability Coverage for Child Development Homes Insurance Act of 1990," was introduced in Council and assigned Bill No. 8-160, which was referred to the Committee on

Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on March 13, 1990, and March 27, 1990, respectively. Signed by the Mayor on April 17, 1990, it was assigned Act No. 8-196 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its

review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-4002. General provisions.

(a) An insurer shall offer to any person who is a licensed caregiver pursuant to 29 DCMR 301, optional liability and comprehensive coverage for up to a total of 5 children and infants. The optional protection shall provide liability coverage for a child or infant who is injured while attending the child development home and comprehensive coverage for property damage to the child development home.

(b) An insurer who offers motor vehicle liability insurance in the District, pursuant to Chapter 24 of this title, may offer to any policyholder who is licensed pursuant to 29 DCMR 301 as a child development home caregiver, optional personal injury protection to cover a child or infant who suffers an injury while a passenger in an automobile operated out of the insured's activities as a child development home caregiver. The coverage required pursuant to this subsection shall be in an amount approved by the Commissioner.

(c) Nothing in this chapter shall prohibit an insurer from denying a child development home caregiver's application for optional insurance or denying liability coverage to an insured for an injury that results from abuse or neglect.

(June 13, 1990, D.C. Law 8-140, § 3, 37 DCR 2651; May 21, 1997, D.C. Law 11-268, § 10(x), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2502.

Legislative history of Law 8-140. — For legislative history of D.C. Law 8-140, see Historical and Statutory Notes following § 31-4001.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4001.

§ 31-4003. Commissioner to establish liability coverage levels.

For purposes of this chapter, the Commissioner shall establish liability coverage levels in rulemaking pursuant to the provisions of subchapter I of Chapter 5 of Title 2.

(June 13, 1990, D.C. Law 8-140, § 4, 37 DCR 2651; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 34, 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-2503.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4001.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill

No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

CHAPTER 41. RISK RETENTION.

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§ 31-4101. Definitions.

For the purposes of this chapter, the term:

(1) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking, or the commissioner, director, or superintendent of insurance in any other state.

(A) Any person who performs that work; or

(B) Any person who hires an independent contractor to perform that work, but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(1A) "Completed operations liability" means liability arising out of installation, maintenance, or repair of any product at a site which is not owned or controlled by:

(2) "District" means the District of Columbia.

(3) "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means:

(A) For a corporation, the state in which the purchasing group is incorporated; and

(B) For an unincorporated entity, the state of its principal place of business.

(4) "Hazardous financial condition" means that, based on its present reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(A) Meet obligations to policyholders with respect to known claims and reasonably anticipated claims;

(B) Pay other obligations in the normal course of business; or

(C) Meet the minimum capital and surplus requirements of licensed property and casualty insurance companies.

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of the District.

(6) "Liability" means legal liability for damages, including costs of defense, legal costs, and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to other persons resulting from or arising out of any business (whether profit or nonprofit), trade, product, services (including professional services), premises,

or operations, or any activity of any state or local government, or any agency or political subdivision thereof. The term "liability" does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. § 51 et seq.).

(7) "NAIC" means National Association of Insurance Commissioners.

(8) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in paragraph (10) of this section.

(9) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(A) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(B) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(C) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(D) Pro forma financial statements and projections;

(E) Appropriate opinions by a qualified, independent casualty actuary including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(F) Identification of management, underwriting, and claims procedures marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

(G) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each state; and

(H) Other matters as may be prescribed by the insurance commissioner of the jurisdiction in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that jurisdiction.

(10) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of the person when the incident giving rise to the claim occurred.

(11) "Purchasing group" means any group which:

(A) Has as one of its purposes the purchase of liability insurance on a group basis;

(B) Purchases liability insurance only for its group members and only to

cover their similar or related liability exposure, as described in subparagraph (C) of this paragraph;

(C) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(D) Is domiciled in any state.

(12) "Risk retention group" means any corporation or other limited liability association:

(A) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(B) Which is organized for the primary purpose of conducting the activity described under subparagraph (A) of this paragraph;

(C) Which is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or which, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance commissioner of at least 1 state that it satisfied the capitalization requirements of that state, except that any group shall be considered a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as these terms were defined in the federal Product Liability Risk Retention Act of 1981, approved September 25, 1981 (95 Stat. 949; 15 U.S.C. § 3901 et seq.), before the date of the enactment of the Liability Risk Retention Act of 1986, approved October 27, 1986 (100 Stat. 3170; 15 U.S.C. § 3901 et seq.);

(D) Repealed.

(E) Which does not exclude any person from membership in the group solely to provide members of the group a competitive advantage over that person;

(F) Which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group, or has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group, and as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group;

(G) Whose members are engaged in businesses or activities similar or related with respect to the liability of which the members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

(H) Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) Reinsurance with respect to the liability of any other risk retention group, or any members of the other group, which is engaged in business or

activities so that the group or a member meets the requirement described in paragraph (9)(G) of this section from membership in the risk retention group which provides the reinsurance; and

(I) The name of which includes the phrase "Risk Retention Group".

(13) "State" means any state of the United States or the District of Columbia.

(14) Repealed.

(Oct. 21, 1993, D.C. Law 10-46, § 2, 40 DCR 6082; Apr. 26, 1994, D.C. Law 10-103, § 4(a), 41 DCR 1005; Feb. 27, 1996, D.C. Law 11-90, §§ 3(a)-(c), 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(aa)(1), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 38(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(z), 51 DCR 2817.)

Cross references. — Reciprocal insurance company to include interinsurance exchange but not risk retention group, see § 31-751.

Section references. — This section is referred to in §§ 31-401, 31-3931.01, 31-3931.12, 31-4103, and 31-4107.

Prior Codifications. — 1981 Ed., § 35-2901.

Effect of amendments. — D.C. Law 15-166, in par. (1), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4(a) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

For temporary (225 day) amendment of section, see § 3(a)-(c) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 3(a) through (c) of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 3(a) through (c) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

For temporary (90 day) amendment of section, see § 4(z) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-46. — Law 10-46, the "Risk Retention Act of 1993," was introduced in Council and assigned Bill No. 10-124, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-91 and transmitted to both

Houses of Congress for its review. D.C. Law 10-46 became effective on October 21, 1993.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and February 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 11-90. — Law 11-90, the "Insurance Omnibus Amendment Act of 1995," was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and

December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-46, the Risk

Retention Act of 1993, see Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

Editor's notes. — Mayor authorized to issue rules: Section 14 of D.C. Law 10-46 provided that the Mayor shall, pursuant to subchapter I of Chapter 15 of Title 1 subchapter I of Chapter 5 of Title 2, 2001 Ed., issue rules to implement the provisions of this chapter.

§ 31-4102. Risk retention groups chartered in the District.

(a)(1) A risk retention group shall be chartered as an association captive insurer licensed pursuant to § 31-3931.01, and licensed to write only liability insurance pursuant to this chapter, and shall comply with all of the laws, rules, and regulations, and requirements applicable to captive insurance companies chartered and licensed in the District and with § 31-4103, to the extent the requirements are not a limitation on laws, rules, regulations, or requirements of the District.

(2) All risk retention groups chartered in the District shall file with the Mayor and the NAIC an annual statement in a form prescribed by the NAIC and in any other form required by the Mayor.

(3) Any license issued pursuant to this section shall be issued as a Financial Services endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(b) Before it may offer insurance in any state, each risk retention group shall also submit to the Mayor a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days of any change. The group shall not offer any additional kinds of liability insurance, in the District or in any other state, until a revision of the plan or study is approved by the Commissioner.

(c)(1) At the time of filing its application for a charter, the risk retention group shall provide to the Commissioner, in summary form, the following information:

- (A) The identity of the initial members of the group;
- (B) The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;
- (C) The amount and nature of initial capitalization;
- (D) The coverages to be afforded; and
- (E) The states in which the group intends to operate.

(2) Upon receipt of this information, the Mayor shall forward the information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of § 31-4103 or any other sections of this chapter.

(Oct. 21, 1993, D.C. Law 10-46, § 3, 40 DCR 6082; Apr. 26, 1994, D.C. Law 10-103, § 4(b), 41 DCR 1005; May 21, 1997, D.C. Law 11-268, § 10(aa)(2), 44 DCR 1730; Apr. 20, 1999, D.C. Law 12-261, § 2003(ll), 46 DCR 3142; Oct. 28,

2003, D.C. Law 15-38, § 3(z), 50 DCR 6913; Mar. 16, 2005, D.C. Law 15-262, § 26, 52 DCR 1205.)

Section references. — This section is referred to in § 31-4103.

Prior Codifications. — 1981 Ed., § 35-2902.

Effect of amendments. — D.C. Law 15-38, in subsec. (a)(3), substituted “Financial Services endorsement to a basic business license under the basic” for “Class A Financial Services endorsement to a master business license under the master”.

D.C. Law 15-262 rewrote subsec. (a)(1) which had read:

“(a)(1) A risk retention group shall be chartered and licensed to write only liability insurance pursuant to this chapter, and, except as provided elsewhere in this chapter, must comply with all of the laws, rules, regulations, and requirements applicable to an insurer chartered and licensed in the District and with § 31-4103 to the extent the requirements are not a limitation on laws, rules, regulations, or requirements of the District.”

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(z) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

For temporary (90 day) amendment of section, see § 26 of Captive Insurance Company Emergency Act of 2004 (D.C. Act 15-640, November 30, 2004, 52 DCR 1238).

Legislative history of Law 10-46. — For legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 12-261. — Law 12-261, the “Second Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 15-38. — For Law 15-38, see notes following § 31-1103.

Legislative history of Law 15-262. — For Law 15-262, see notes following § 31-3901.

§ 31-4103. Risk retention groups not chartered in the District.

Risk retention groups chartered and licensed in states other than the District seeking to do business as a risk retention group in the District shall comply with the laws of the District as follows:

(1)(A) Before offering insurance in the District, a risk retention group shall submit to the Mayor on a form prescribed by the NAIC:

(i) A statement identifying the state or states in which the retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and any other information, including information on its membership, as the Mayor may require to verify that the risk retention group is qualified under § 31-4101(12); and

(ii) A copy of its plan of operations or feasibility study and revisions of the plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which was defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. § 3901 et seq.), before October 27, 1986, and which was offered before the date by any

risk retention group which had been chartered and operating for not less than 3 years before the date.

(B) The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by § 31-4102(b) at the same time that the revision is submitted to the commissioner of its chartering state.

(C) The risk retention group shall submit a statement of registration, for which a filing fee shall be determined by the Mayor, proof of compliance with the service of process provisions of § 31-202.

(2) Any risk retention group doing business in the District shall submit to the Mayor:

(A) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist under criteria established by the NAIC;

(B) A copy of each examination of the risk retention group as certified by the Commissioner or public official conducting the examination;

(C) Upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

(D) Any information required to verify its continuing qualification as a risk retention group under § 31-4101(12).

(3)(A) Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within the District, and shall report to the Commissioner the net premiums written for risks resident or located within the District. Such a risk retention group shall be subject to taxation, and any related applicable fines and penalties, on the same basis as a foreign admitted insurer.

(B) To the extent licensed agents or brokers are utilized pursuant to § 31-4111, they shall report to the Commissioner the premiums for direct business for risks resident or located within the District which these licensees have placed with or on behalf of a risk retention group not chartered in the District of Columbia.

(C) To the extent that insurance agents or brokers are utilized pursuant to § 31-4111, the agent or broker shall keep a complete and separate record of all policies procured from each risk retention group, which record shall be open to examination by the Commissioner, as provided by the insurance laws of the District of Columbia. These records shall contain each policy and each kind of insurance provided thereunder, and shall include the following:

- (i) The limit of liability;
- (ii) The time period covered;
- (iii) The effective date;
- (iv) The name of the risk retention group which issued the policy;
- (v) The gross premium charged; and
- (vi) The amount of return premiums, if any.

(4) Any risk retention group, its agents, and representatives shall comply with District law governing fraud or deceptive practices. If the Mayor seeks an

injunction regarding this conduct, the injunction shall be obtained from a court of competent jurisdiction.

(5) Any risk retention group shall comply with the laws governing the proper transaction of insurance business as provided by the District.

(6) Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the superintendent or Commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination within 60 days after a request by the Commissioner of the District. Any examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook. Cost of the examination shall be borne by the risk retention group.

(7) Every application form for insurance from a risk retention group, and every policy, on its front and declaration page issued by a risk retention group, shall contain in 10-point type the following notice:

“NOTICE

“This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.”.

(8) The following acts by a risk retention group are prohibited:

(A) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(B) The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

(9) After April 26, 1994, risk retention groups shall not be allowed to do business in the District if an insurance company is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(10) The terms of any insurance policy issued by risk retention groups shall not provide, or be construed to provide, coverage prohibited generally by a statute of the District or declared unlawful by the highest court of the District whose law applies to such a policy.

(11) A risk retention group not chartered in the District and doing business in the District shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under paragraph (6) of this section.

(12) A risk retention group that violates any provision of this chapter will be subject to fines and penalties, including revocation of its right to do business in the District, applicable to licensed insurers generally.

(13) In addition to complying with the requirements of this section, any risk retention group operating in the District prior to enactment of this chapter shall, within 30 days after October 21, 1993, comply with paragraph (1) of this section.

(Oct. 21, 1993, D.C. Law 10-46, § 4, 40 DCR 6082; Apr. 26, 1994, D.C. Law 10-103, § 4(c), 41 DCR 1005; Mar. 21, 1995, D.C. Law 10-233, § 8, 42 DCR 24; May 16, 1995, D.C. Law 10-255, § 47, 41 DCR 5193; Feb. 27, 1996, D.C. Law 11-90, §§ 3(d)-(f), 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(aa)(2), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 38(b), 45 DCR 745.)

Section references. — This section is referred to in § 31-4102.

Prior Codifications. — 1981 Ed., § 35-2903.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 4(c) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

For temporary (225 day) amendment of section, see § 3(d)-(f) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 3(d) through (f) of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 3(d) through (f) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 10-46. — For legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 10-103. — For legislative history of D.C. Law 10-103, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of

1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 10-255. — Law 10-255, the “Technical Amendments Act of 1994,” was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Legislative history of Law 11-90. — For legislative history of D.C. Law 11-90, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4101.

§ 31-4104. Restrictions.

(a) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in the District, nor shall any risk retention group or its insureds or claimants against its insureds, receive any benefit from such a fund for claims arising under the insurance policies issued by the risk retention group.

(b) When a purchasing group obtains insurance covering its members from an insurer not authorized in this state, or a risk retention group, no risks, resident or located, shall be covered by any insurance guaranty fund or similar mechanism in the District.

(c) When a purchasing group obtains insurance covering its members’ risks from an authorized insurer, only risks resident or located in the District shall be covered by the District property and liability guaranty fund.

(Oct. 21, 1993, D.C. Law 10-46, § 5, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2904. legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.
Legislative history of Law 10-46. — For

§ 31-4105. Countersignatures not required.

A policy of insurance issued to a risk retention group, or any member of that group, shall not be required to be countersigned as otherwise provided in the District of Columbia insurance law.

(Oct. 21, 1993, D.C. Law 10-46, § 6, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2905. legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.
Legislative history of Law 10-46. — For

§ 31-4106. Purchasing groups — Exemption from certain laws.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of the District, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

- (1) Prohibit the establishment of a purchasing group;
- (2) Make it unlawful for an insurer to provide, or offer to provide, insurance on a basis providing to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters;
- (3) Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph (2) of this section;
- (4) Prohibit a purchasing group from obtaining insurance on a group because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;
- (5) Require that a purchasing group must have a minimum number of common ownership or affiliation, or certain legal form;
- (6) Require that a certain percentage of a purchasing group must obtain insurance on a group basis;
- (7) Otherwise discriminate against a purchasing group or any of its members; or
- (8) Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in the District.

(Oct. 21, 1993, D.C. Law 10-46, § 7, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2906. legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.
Legislative history of Law 10-46. — For

§ 31-4107. Notice and registration requirements of purchasing groups.

(a) A purchasing group which intends to do business in the District shall, prior to doing business, furnish notice to the Commissioner which shall:

- (1) Identify the state in which the group is domiciled;
- (2) Identify all other states in which the group intends to do business;
- (3) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(4) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of each company;

(5) Specify the method by which, and the person or persons, if any, through whom, the insurance will be offered to its members whose risks are resident or located in the District;

(6) Identify the principal place of business of the group; and

(7) Provide any other information required by the Commissioner to verify that the purchasing group is qualified under § 31-4101(11).

(b) A purchasing group shall, within 10 days, notify the Commissioner of any changes in any of the items set forth in subsection (a) of this section.

(c) The purchasing group shall register with the District and provide proof of compliance with the service of process provisions of § 31-202, for which a filing fee shall be determined by the Commissioner, except that these requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. § 3901 et seq.), and:

(1) Which was domiciled in any state of the United States before April 1, 1986, and after October 27, 1986;

(2) Which purchased insurance from an insurance carrier licensed in any state before October 27, 1986, and since October 27, 1986; or

(3) Which was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. § 3901 et seq.), before October 27, 1986.

(d) Each purchasing group that is required to give notice pursuant to subsection (a) of this section shall also furnish information required by the Commissioner to:

- (1) Verify that the entity qualifies as a purchasing group;
- (2) Determine where the purchasing group is located; and
- (3) Determine appropriate tax treatment.

(e) Any purchasing group which was doing business in the District prior to the enactment of this chapter shall, within 30 days after October 21, 1993, furnish notice to the Mayor pursuant to the provisions of subsection (a) of this section and furnish the information required pursuant to subsections (b) and (c) of this section.

(Oct. 21, 1993, D.C. Law 10-46, § 8, 40 DCR 6082; Mar. 21, 1995, D.C. Law 10-233, § 9, 42 DCR 24; May 21, 1997, D.C. Law 11-268, § 10(aa)(2), 44 DCR 1730.)

Section references. — This section is referred to in § 31-4111.

Prior Codifications. — 1981 Ed., § 35-2907.

Legislative history of Law 10-46. — For legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 10-233. — For legislative history of D.C. Law 10-233, see Historical and Statutory Notes following § 31-4103.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4101.

§ 31-4108. Restrictions on insurance purchased by purchasing groups.

(a) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such a state.

(b) A purchasing group which obtains liability insurance from an insurer not admitted in the District or a risk retention group shall inform each of the members of the group that has a risk resident or located in the District that such a risk is not protected by an insurance insolvency guaranty fund in the District, and that the risk retention group or the insurer may not be subject to all the insurance laws and regulations of the District.

(c) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

(d) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

(Oct. 21, 1993, D.C. Law 10-46, § 9, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2908.

Legislative history of Law 10-46. — For

legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

§ 31-4109. Purchasing group taxation.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in the District by a purchasing group or any members of the purchasing groups shall be:

(1) Imposed at the same rate and subject to the same interest, fines, and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(2) Paid first by the insurance source, and if not by the source by the agent or broker for the purchasing group, and if not by the agent or broker then by the purchasing group, and if not by the purchasing group then by each of its members.

(Oct. 21, 1993, D.C. Law 10-46, § 10, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2909. legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 10-46. — For

§ 31-4110. Administrative and procedural authority regarding risk retention groups and purchasing groups.

The Commissioner is authorized to make use of any of the powers established under the Insurance Code of the District of Columbia to enforce the laws of the District of Columbia not specifically preempted by the federal Liability Risk Retention Act of 1986 (15 U.S.C. § 3901 et seq.), including the Commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties, and seek injunctive relief. With regard to any investigation, administrative proceedings, or litigation, the Commissioner can rely on the procedural laws of the District. The injunctive authority of the Commissioner, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

(Oct. 21, 1993, D.C. Law 10-46, § 11, 40 DCR 6082; Apr. 9, 1997, D.C. Law 11-255, § 41, 44 DCR 1271; May 21, 1997, D.C. Law 11-268, § 10(aa)(2), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-2910.

Legislative history of Law 10-46. — For legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 11-255. — Law 11-255, the "Second Technical Amendments Act of 1996," was introduced in Council and assigned Bill No. 11-, which was referred to the Committee of the Whole. The Bill was adopted

on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-519 and transmitted to both Houses of Congress for its review. D.C. Law 11-255 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4101.

§ 31-4111. Duty of agents or brokers to obtain license.

(a) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance in the District from a risk retention group unless the person, firm, association, or corporation is licensed as an insurance agent or broker in accordance with the District of Columbia insurance licensing laws.

(b)(1) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance in the District for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless the person, firm, association, or corporation is licensed as an insurance agent or broker in accordance with the District of Columbia insurance licensing laws.

(2) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in the District for any member of a purchasing group under a purchasing group's

policy unless the person, firm, association, or corporation is licensed as an insurance agent or broker in accordance with the District of Columbia insurance licensing laws.

(3) No person, firm, association, or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance from an insurer not authorized to do business in the District on behalf of a purchasing group located in this state unless the person, firm, association, or corporation is licensed as a surplus lines agent or excess line broker in accordance with the District of Columbia insurance licensing laws.

(c) For purposes of acting as an agent or broker for a risk retention or purchasing group pursuant to subsections (a) and (b) of this section, the requirement of residence in the District shall not apply.

(d) Every person, firm, association, or corporation licensed pursuant to the provisions of Chapter 28 of Title 47, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by § 31-4108(b) in the case of a risk retention group and § 31-4107(c) in the case of a purchasing group.

(Oct. 21, 1993, D.C. Law 10-46, § 12, 40 DCR 6082; Feb. 27, 1996, D.C. Law 11-90, § 3(g), 42 DCR 7155.)

Section references. — This section is referred to in § 31-4103.

Prior Codifications. — 1981 Ed., § 35-2911.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3(g) of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 3(g) of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR

2544) and § 3(g) of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 10-46. — For legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

Legislative history of Law 11-90. — For legislative history of D.C. Law 11-90, see Historical and Statutory Notes following § 31-4101.

§ 31-4112. Binding effect of orders issued in United States District Court.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state, or in all states or in any territory or possession of the United States, upon finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the courts of the state.

(Oct. 21, 1993, D.C. Law 10-46, § 13, 40 DCR 6082.)

Prior Codifications. — 1981 Ed., § 35-2912.

Legislative history of Law 10-46. — For

legislative history of D.C. Law 10-46, see Historical and Statutory Notes following § 31-4101.

SUBTITLE VI. LIFE AND RELATED INSURANCE.

SUBDIVISION A. LIFE INSURANCE ACT.

CHAPTER 42. DEFINITIONS.

Sec.

31-4201. Short title; applicability of provisions.

Sec.

31-4202. Definitions.

§ 31-4201. Short title; applicability of provisions.

This subdivision shall be known as the “Life Insurance Act.” All life insurance companies now or hereafter incorporated or formed by authority of any general or special law of this District or by other act of Congress, and all foreign and alien companies authorized to do business in this District, shall be subject to said chapters.

(June 19, 1934, 48 Stat. 1127, ch. 672, ch. I, § 1.)

Cross references. — Application of chapter to existing companies, see § 31-4420.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-301. 1973 Ed., § 35-301.

CASE NOTES

ANALYSIS

Construction and application.
Licensing.

Construction and application.

The Navy Mutual Aid Association formed to aid families of deceased members, by providing a substantial sum for their relief at as near actual net cost of insurance as possible, and by securing for them without cost, pensions to which they may be entitled, was subject to the provisions of the Life Insurance Act but not subject to the tax on insurance companies. D.C. Code 1951, §§ 35-301 to 35-803, 47-1801 to 47-1808. *Fechteler v. Jordan*, 218 F.2d 865, 1955 U.S. App. LEXIS 2856 (C.A.D.C. 1955).

Licensing.

Where insurance company, which made a loan to prior owners of hotel for purpose of providing funds for refinancing hotel property and for refurbishing and renovating the hotel, at all pertinent times was licensed to do business in the District of Columbia under the Life

Insurance Act, the company was exempt from the licensing requirements of the Money Lenders Act. D.C. Code §§ 26-601, 26-610(a), 28-3301, 35-301 et seq. *National Life Ins. Co. v. Silverman*, 454 F.2d 899, 1971 U.S. App. LEXIS 11212 (C.A.D.C. 1971).

Insurer who seeks licenses under the Life Insurance Act and the Fire and Casualty Act bears responsibility of satisfying the more stringent requirement regardless of which statute prescribes it, and if two certificates are issued, each must stand on its own feet. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

Life Insurance Act of District of Columbia and Fire and Casualty Act do not prohibit issuance of certificate or certificates authorizing a single insurer to do both life and casualty insurance business. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

§ 31-4202. Definitions.

In this subdivision, unless the context otherwise requires:

- (1) “District” means the District of Columbia.
- (2) “Mayor” means the Mayor of the District of Columbia.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking of the District of Columbia, or the officer or officers, agency or agencies succeeding to his functions under Reorganization Plan No. 5 of 1952.

(4) "Department" means the Department of Insurance, Securities, and Banking of the District of Columbia.

(5) "Company" means any life insurance company and includes a corporation, company, or association of persons engaged in, or proposing to engage in, the business of life insurance.

(6) "Domestic company" means an insurance company organized under the laws of the District, or formed or organized under an act of Congress.

(7) "Foreign company" means an insurance company organized under the laws of any state of the United States, or of any territory or insular possession of the United States.

(8) "Alien company" means a company organized under the laws of any country other than the United States or a territory or insular possession thereof.

(9) "Person" includes individuals, corporations, associations, and partnerships; personal pronouns include all genders; the singular includes the plural, and the plural includes the singular.

(10) The term "general agent" in this subdivision shall include an individual, copartnership, or corporation authorized in writing by a company, association, or exchange to solicit risks and collect premiums, and/or issue policies in its behalf.

(11) The term "agent" in this subdivision shall include an individual, copartnership, or corporation authorized in writing by a company, association, or exchange to solicit risks and collect premiums in its behalf.

(12) The term "solicitor" in this subdivision shall include any individuals authorized in writing by a duly licensed agent to solicit risks and collect premiums in behalf of said agent.

(13) The terms "agent" and "solicitor" shall not include officers or salaried employees of any company, association, or exchange which is authorized to transact business in the District, who do not solicit, negotiate, or place risks.

(14) The term "broker" in this subdivision shall include consultant, surveyor and/or any person, partnership, association, or corporation who, for money, commission, or anything of value, acts or aids in any manner on behalf of the insured in negotiating contracts of insurance or placing risks or taking out insurances, including surety bonds.

(15) "Net premium receipts" means gross premiums received less the sum of the following:

(A) Premiums returned on policies cancelled or not taken;

(B) Premiums paid for reinsurances where the same are paid to companies duly licensed to do business in the District; and

(C) Dividends paid in cash or used by policyholders in payment of renewal premiums or in purchase of paid-up additional insurance.

(16) "Surplus" means the excess of admitted assets over liabilities and capital, in the case of a company with capital stock, and the excess of admitted assets over liabilities in the case of a company without capital stock.

(17) "Liabilities" means all debts, due or to become due, contingent or otherwise, of which the company has knowledge, and includes the reserves required by this subdivision.

(18) "Industrial life insurance" means that form of life insurance, either: (A) Under which the premiums are payable weekly; or (B) under which the premiums are payable monthly or oftener; if the face amount of insurance provided in the policy is less than \$1,000, and the words "industrial policy" are plainly printed upon the policy as a part of the descriptive matter.

(19) "Admitted assets" includes the investments authorized or permitted pursuant to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(20) "Domestic partner" shall have the same meaning as provided in § 32-701(3).

(21) "Domestic partnership" shall have the same meaning as provided in § 32-701(4).

(June 19, 1934, 48 Stat. 1128, ch. 672, ch. I, § 2; July 16, 1953, 67 Stat. 172, ch. 196, § 2; Apr. 26, 1994, D.C. Law 10-103, § 2, 41 DCR 1005; May 21, 1997, D.C. Law 11-268, § 10(h), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 21, 45 DCR 745; June 12, 2003, D.C. Law 14-310, § 8, 50 DCR 1092; June 11, 2004, D.C. Law 15-166, § 4(aa), 51 DCR 2817; Sept. 12, 2008, D.C. Law 17-231, § 28(a), 55 DCR 6758.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Section references. — This section is referred to in §§ 22-3225.01 and 31-701.

Prior Codifications. — 1981 Ed., § 35-302. 1973 Ed., § 35-302.

Effect of amendments. — D.C. Law 14-310, in par. (4), validated a previously made technical correction.

D.C. Law 15-166, in par. (3), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities"; and, in par. (4), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation".

D.C. Law 17-231 added pars. (20) and (21).

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(aa) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory

Affairs. The Bill was adopted on first and second readings on January 4, 1994, and February 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the "Technical Amendments Act of 1998," was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997 and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 14-310. — Law 14-310, the "Criminal Code and Miscellaneous

Technical Amendments Act of 2002", was introduced in Council and assigned Bill No. 14-954, which was referred to the Committee on Whole. The Bill was adopted on first and second readings on December 3, 2002, and December 17, 2002, respectively. Signed by the Mayor on January 22, 2003, it was assigned Act No. 14-622 and transmitted to both Houses of Congress for its review. D.C. Law 14-310 became effective on June 12, 2003.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 17-231. — For Law 17-231, see notes following § 31-3301.01.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner

of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Compensation.
Expenses.

Compensation.

Remuneration, which is not "wages for employment" within meaning of District of Columbia Unemployment Compensation Act, is eliminated from a claimant's "base period wages," when computing unemployment benefits. D.C. Code §§ 46-301 et seq., 46-307. *Gordon v. District Unemployment Compensation Board*, 402 A.2d 1251, 1979 D.C. App. LEXIS 389 (1979).

Unemployment compensation case would be remanded to Unemployment Compensation Board to determine whether insurer's debit agent was compensated solely by commission as required by insurance agent exemption from benefits or whether fringe benefits and expense allowance provided debit agent constituted remuneration not solely in form of commission so that he was without exemption and entitled to

benefits, where it was not clear whether debit agent's vacation pay was calculated on a commission or flat salary basis, and record lacked testimony regarding debit agent's means of payment under complicated employment contracts in question. D.C. Code §§ 46-301 et seq., 46-301(b)(5)(L). *Gordon v. District Unemployment Compensation Board*, 402 A.2d 1251, 1979 D.C. App. LEXIS 389 (1979).

Expenses.

Expense allowances, to the extent of reimbursement, and group insurance benefits are not compensation for purposes of determining whether an unemployment compensation claimant falls within statutory exclusion of persons who performed service as insurance agents and were paid solely by commission, and thus neither of these categories interferes with requirement of remuneration by commission. D.C. Code § 46-301(c). *Gordon v. District Unemployment Compensation Board*, 402 A.2d 1251, 1979 D.C. App. LEXIS 389 (1979).

CHAPTER 43. DEPARTMENT OF INSURANCE, SECURITIES AND BANKING WITH RESPECT TO LIFE COMPANIES.

Sec.

- 31-4301. Department continued; personnel; performance of Commissioner's duties; seal; Commissioner's office and papers to be public; Commissioner's annual reports; out-of-state visits.
- 31-4302. Collection of charges and fees.
- 31-4303. Disposition of excess in fees, charges, or taxes.
- 31-4304. Certificate of authority — Investigation of qualifications; effect; issuance.
- 31-4305. Certificate of authority — Revocation or suspension; grounds; hearing; alternative penalty.
- 31-4306 to 31-4309. [Repealed].
- 31-4310. Representation of financial standing — Alien companies; violations.
- 31-4311. [Repealed].
- 31-4312. Commissioner authorized to issue subpoenas; enforcement.
- 31-4313. Enforcement of Commissioner's orders or actions.

Sec.

- 31-4314. False statements in application for policy.
- 31-4315. Deposit of securities by companies desiring to transact business — Amount; deposits outside District.
- 31-4316. Deposit of securities by companies desiring to transact business — Type of securities allowed; officials responsible for safekeeping; collection of income; substitution; decline in value.
- 31-4317. Deposit of securities by companies desiring to transact business — Withdrawal upon discontinuance of business or reinsurance.
- 31-4318 to 31-4328. [Repealed].
- 31-4329. Disposition of premiums paid to agents.
- 31-4330. Contractual rights of minors.
- 31-4331. Assessment companies prohibited.
- 31-4332. Appeals from Commissioner to Mayor.

§ 31-4301. Department continued; personnel; performance of Commissioner's duties; seal; Commissioner's office and papers to be public; Commissioner's annual reports; out-of-state visits.

(a) There shall be continued in the District a department charged with the execution of the laws relating to insurance, to be called the "Department of Insurance, Securities, and Banking." At the head of such Department there shall be a Commissioner of the Department of Insurance, Securities, and Banking, who shall devote his entire service to the Department. He shall be appointed by and hold his office at the pleasure of the Mayor. The Commissioner, during his term of office, shall not be interested in the business of any insurance company except as a policyholder. He shall take and subscribe an oath of office which shall be filed with the Mayor. In said Department there shall be also 2 Deputy Commissioners and such other personnel as may be necessary within appropriations annually made by Congress for said Department. The compensation of the Commissioner, Deputy Commissioners, and other personnel shall be fixed in accordance with the provisions of Chapter 51 and subchapter III of Chapter 53 of Title 5, United States Code [5 U.S.C. § 5101 et seq. and 5 U.S.C. § 5331 et seq.].

(b) In case of the absence or inability of the Commissioner, or in the event of the removal of the Commissioner, and pending the appointment of his successor, one of the Deputy Commissioners shall perform the duties of the Commissioner.

(c) The Mayor shall provide the Department with an official seal, which shall be the seal of the District of Columbia surrounded by a border in which shall appear "Department of Insurance, Securities, and Banking."

(d) Every certificate and other document or paper executed by such Commissioner, or his deputies, in pursuance of any authority conferred upon him by law and sealed with the seal of his office, and all copies of papers certified by him or by his deputies and authenticated by said seal, shall, in all cases, be evidence equally and in like manner as the original thereof and shall have the same force and effect as would the original in any suit or proceeding in any court of this District.

(e) The office of the Commissioner shall be a public office, and the records, books, and papers thereof on file therein shall be public records of the District, except as it may be provided otherwise herein.

(f) The Commissioner shall report annually to the Mayor his official transactions, and shall include in such report abstracts of the annual statements of the several companies and an exhibit of the financial condition and business transactions of the same as shown by their annual statements. He shall also include therein a statement of the receipts and expenditures of the Department for the preceding year and such recommendations relative to insurance and the insurance laws of the District as he shall deem proper.

(g) The Commissioner is authorized to attend and participate in the meetings of the National Convention of Insurance Commissioners and of the committees thereof; he is also authorized to visit the insurance departments of the various states when in his judgment such visits are necessary for the proper conduct of his official office; and he may require such of his assistants as he may designate to attend and participate in such meetings, all subject to the prior approval of the Mayor. The actual expense of such attendance by the Commissioner and his assistants shall be paid in like manner as other expenses of the District are paid.

(June 19, 1934, 48 Stat. 1129, ch. 672, ch. II, § 1; Oct. 28, 1949, 63 Stat. 972, ch. 782, title XI, § 1106(a); May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 22(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(bb), 51 DCR 2817; Mar. 2, 2007, D.C. Law 16-191, § 55, 53 DCR 6794.)

Cross references. — Application of chapter to existing companies, see § 31-4420.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-401. 1973 Ed., § 35-401.

Effect of amendments. — D.C. Law 15-166, in subsecs. (a) and (c), substituted "Department of Insurance, Securities, and Banking" for "Department of Insurance and Securities Regulation"; and, in subsec. (a), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities".

D.C. Law 16-191, in subsec. (c), validated a previously made technical correction.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(bb) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its

review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997 and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The

executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-4302. Collection of charges and fees.

(a) All charges and fees provided for in this section shall be collected by the Commissioner and made payable to the District of Columbia.

(b) For filing charter or articles of incorporation or association, or deed of settlement or copy thereof, required by law, \$300; for each company certificate of authority, \$200, renewal fee, \$200; for license of each general agent, \$100, renewal fee, \$100; for license of each agent, or solicitor, \$50, renewal fee \$50; for license of each broker, \$100, renewal fee, \$100. For each appointment fee for each agent, general agent, or each solicitor, \$25 fee, \$25 renewal fee; provided, however, that beginning October 1, 1994, the license and renewal fee of each general agent, agent or solicitor, and broker shall be payable biennially in accordance with the rulemaking procedures in section 3(a)(2).

(c) The Mayor may amend all fees referred to in this chapter by rulemaking pursuant to subchapter I of Chapter 5 of Title 2.

(June 19, 1934, 48 Stat. 1130, ch. 672, ch. II, § 2; Feb. 23, 1980, D.C. Law 3-52, § 2, 27 DCR 26; June 14, 1994, D.C. Law 10-128, § 401, 41 DCR 2096; Feb. 27,

1996, D.C. Law 11-90, § 10, 42 DCR 7155; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Taxation and fiscal affairs of insurance companies, see § 47-2601 et

Prior Codifications. — 1981 Ed., § 35-402. 1973 Ed., § 35-402.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 10 of Insurance Omnibus Temporary Amendment Act of 1995 (D.C. Law 11-36, September 8, 1995, law notification 42 DCR 5305).

Emergency legislation. — For temporary amendment of section, see § 11 of the Insurance Omnibus Emergency Amendment Act of 1995 (D.C. Act 11-48, May 15, 1995, 42 DCR 2544) and § 10 of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 3-52. — Law 3-52, the “District of Columbia Insurance Act Amendment of 1979,” was introduced in Council and assigned Bill No. 3-53, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 20, 1979, and December 4, 1979, respectively. Signed by the Mayor on December 21, 1979, it was assigned Act No. 3-142 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-128. — Law 10-128, the “Omnibus Budget Support Act of

1994,” was introduced in Council and assigned Bill No. 10-575, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on March 22, 1994, and April 12, 1994, respectively. Signed by the Mayor on April 14, 1994, it was assigned Act No. 10-225 and transmitted to both Houses of Congress for its review. D.C. Law 10-128 became effective on June 14, 1994.

Legislative history of Law 11-90. — Law 11-90, the “Insurance Omnibus Amendment Act of 1995,” was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

References in text. — “Section 3(a)(2),” referred to in (b), is § 3(a)(2) of chapter II of the Life Insurance Act, approved June 19, 1934, Pub. L. 73-436, 48 Stat. 1130, ch. 672.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4303. Disposition of excess in fees, charges, or taxes.

Whenever it appears to the satisfaction of the Commissioner that, because of some error, mistake, or erroneous interpretation of a statute, a company has paid fees, charges, or taxes in excess of the amount legally chargeable against it, the Commissioner shall, on application of the company, present the matter to the Mayor, with the view of refunding to such company any such excess, or applying the excess or portion thereof toward the payment of fees, charges, or taxes already due from such company.

(June 19, 1934, 48 Stat. 1131, ch. 672, ch. II, § 4; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Tax refunds, see §§ 47-1317, 47-1318.

Prior Codifications. — 1981 Ed., § 35-403. 1973 Ed., § 35-403.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4301.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commis-

sioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat.

818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-4304. Certificate of authority — Investigation of qualifications; effect; issuance.

(a) The Commissioner shall issue a certificate of authority to a company when it shall have complied with the requirements of the laws of the District so as to be entitled to do business therein. The Commissioner may, however, satisfy himself by such investigation as he may consider proper or necessary that the company is duly qualified under the laws of the District to transact business therein, and may refuse to issue or renew a certificate to a company if the issuance or renewal of the certificate would adversely affect the public interest. In each case, the certificate shall be issued under the seal of the Commissioner, authorizing and empowering the company to transact the kind of business specified in the certificate, and the certificate shall expire on the 30th day of April next succeeding the date of its issuance.

(b) Repealed.

(c) No company shall transact any business of insurance in or from the District until it shall have received a certificate of authority as authorized by this section, and no company shall transact any business of insurance not specified in such certificate of authority.

(June 19, 1934, 48 Stat. 1131, ch. 672, ch. II, § 5; Feb. 22, 1958, 72 Stat. 19, Pub. L. 85-334, § 1; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-190, § 2(a), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 602(a), 49 DCR 6968; Mar. 8, 2007, D.C. Law 16-232, § 205(a)(1), 54 DCR 368.)

Cross references. — Authority of the Council to regulate, modify, or eliminate license requirements and promulgate regulations, see §§ 47-2842, 47-2844.

Revocation of certificates of authority, see § 31-4305.

Section references. — This section is referred to in §§ 31-301 and 31-1501.

Prior Codifications. — 1981 Ed., § 35-404. 1973 Ed., § 35-404.

Effect of amendments. — D.C. Law 13-190 inserted the fourth and fifth sentences.

D.C. Law 14-190 rewrote the section which had read as follows: "It shall be the duty of the Commissioner to issue a certificate of authority to a company when it shall have complied with the requirements of the laws of the District so as to be entitled to do business therein. The

Commissioner may, however, satisfy himself by such investigation as he may deem proper or necessary that such company is duly qualified under the laws of the District to transact business therein, and may refuse to issue or renew any such certificate to a company if the issuance or renewal of such certificate would adversely affect the public interest. In each case the certificate shall be issued under the seal of the Commissioner, authorizing and empowering the company to transact the kind or kinds of business specified in the certificate, and each such certificate shall be made to expire on the 30th day of April next succeeding the date of its issuance. A company may, at its own option and expense, submit a statement from an independent organization acceptable to the Commissioner, attesting that it meets all the require-

ments of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority. The statement shall be signed, under oath, by an officer or principal of the independent organization and shall be considered prima facie evidence by the Commissioner that the company is entitled to do business in the District, subject to (1) an investigation and review, and (2) the Commissioner's authority to revoke or suspend a certificate of authority as provided in this subdivision. No company shall transact any business of insurance in or from the District until it shall have received a certificate of authority as authorized by this section, and no company shall transact any business of insurance not specified in such certificate of authority."

D.C. Law 16-232 repealed subsec. (b), which formerly read:

"(b)(1) A company may, at its own option and expense, submit a statement from an independent organization acceptable to the Commissioner, attesting that it meets all the requirements of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority. The statement shall be signed, under oath, by an officer or principal of the independent organization and shall be considered prima facie evidence by the Commissioner that the company is entitled to do business in the District, subject to an investigation and review and the Commissioner's authority to revoke or suspend a certificate of authority as provided in this subdivision.

"(2) A company may, at its option, submit a certified copy of its current certificate of authority to do business from the jurisdiction where it is organized ('home jurisdiction') and where it conducts its largest volume of business ('largest volume jurisdiction'), if different than its home jurisdiction, together with a statement by a corporate officer that it meets all the requirements of the laws and regulations of the District and is qualified to transact the business for which it seeks a certificate of authority; provided, that the company's home jurisdiction and largest volume jurisdiction have been determined by the Commissioner to have legal and regulatory requirements that meet or exceed those applicable to insurance companies under District law. The statement of the corporate officer shall be signed, under oath, and shall, together with certified copies of the company's certificates of authority, be considered prima facie evidence by the Commissioner that the company is entitled to do business in the District. Nothing in the preceding sentence shall limit the Commissioner's authority to subject the applicant to investigation and re-

view or to suspend a certificate of authority as provided in this subdivision. As a condition of obtaining a certificate of authority to do business in the District, the Commissioner may also require a company submitting a certificate of authority from an alien jurisdiction to submit a power of attorney and undertaking, in a form acceptable to the Commissioner, that provide that the company will not set up a defense to any claim, action, or proceeding brought against it arising from an insurance contract entered into in the District, refuse to obey any lawful order of the Commissioner, or pay any fine or penalty imposed upon it by the Commissioner or any court of competent jurisdiction, on the ground that it is not subject to the laws of the United States of America or the District. The Commissioner shall publish annually in the District of Columbia Register a list of foreign and alien jurisdictions that have been determined by the Commissioner as having legal and regulatory requirements that meet or exceed those applicable to insurance companies under District law. The Commissioner may at any time add or remove jurisdictions from the list and the additions and deletions shall be effective immediately until the next annual publication date."

Emergency legislation. — For temporary (90 day) amendment of section, see § 602(a) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Legislative history of Law 13-190. — Law 13-190, the "Insurer and Health Maintenance Organization Self-Certification Act of 2000," was introduced in Council and assigned Bill No. 13-722, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 2, 2000, it was assigned Act No. 13-407 and transmitted to both Houses of Congress for its review. D.C. Law 13-190 became effective on October 21, 2000.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

Short title. — Short title of title VI of Law 14-190: Section 601 of D.C. Law 14-190 provided that title VI of the act may be cited as the Insurer and Health Maintenance Organization Self-Certification Amendment Act of 2002.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

CASE NOTES

ANALYSIS

Charitable organizations.
Hearings.
Multiple certificates.
Review.

Charitable organizations.

Where metropolitan police retiring association was incorporated as a charitable organization, membership was limited to members of metropolitan police department, the White House police, and park police, purpose of association was to furnish financial relief to members in case of their retirement from police force, and payments upon retirement were principally the amounts of retirees' own contributions with some increment of interest from investments which were required to be approved by majority of board of directors and by majority vote of membership in regular session, association was not engaged in "insurance" and hence was not required to obtain certificate of authority from Superintendent of Insurance. D.C. Code 1961, §§ 29-601, 35-101, 35-102, 35-105, 35-202, 35-404, 35-1305, 35-1320, 35-1321. *Metropolitan Police Retiring Ass'n v. Tobriner*, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

Hearings.

Statute authorizing District of Columbia Superintendent of Insurance, upon satisfying himself by such investigation as he may deem proper or necessary, to refuse to issue or renew certificate, does not authorize superintendent to hold hearing, and grant of hearing by him on

question of renewal of certificate was gratuitous. D.C. Code 1951, § 35-404. *Jordan v. United Ins. Co. of America*, 289 F.2d 778, 1961 U.S. App. LEXIS 4963 (C.A.D.C. 1961).

Multiple certificates.

Insurer who seeks licenses under the Life Insurance Act and the Fire and Casualty Act bears responsibility of satisfying the more stringent requirement regardless of which statute prescribes it, and if two certificates are issued, each must stand on its own feet. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

Life Insurance Act of District of Columbia and Fire and Casualty Act do not prohibit issuance of certificate or certificates authorizing a single insurer to do both life and casualty insurance business. D.C. Code 1951, §§ 35-301 to 35-803, 35-404, 35-1301 to 35-1350, 35-1305. *Travelers Ins. Co. v. Jordan*, 287 F.2d 347, 1961 U.S. App. LEXIS 5253 (C.A.D.C. 1961).

Review.

It was proper for District Court to grant trial de novo, rather than merely reviewing administrative record, in insurer's action against District of Columbia Superintendent of Insurance to set aside ruling denying renewal of certificate of authority, where statutes did not provide for administrative hearing, notwithstanding fact that superintendent had granted one. D.C. Code 1951, § 35-404. *Jordan v. United Ins. Co. of America*, 289 F.2d 778, 1961 U.S. App. LEXIS 4963 (C.A.D.C. 1961).

§ 31-4305. Certificate of authority — Revocation or suspension; grounds; hearing; alternative penalty.

(a) The Commissioner shall have power to revoke or suspend the certificate of authority to transact business in the District of any company which has failed or refused to comply with any provision or requirement of this subdivision, or which:

- (1) Is impaired in capital or surplus;
- (2) Is insolvent;
- (3) Is in such a condition that its further transaction of business in the District would be hazardous to its policyholders or creditors or to the public;
- (4) Has refused or neglected to pay a valid final judgment against such company within 30 days after such judgment shall have become final either by expiration without appeal within the time when such appeal might have been perfected, or by final affirmance on appeal;
- (5) Has violated any law of the District or has in the District violated its charter or exceeded its corporate powers;
- (6) Has refused to submit its books, papers, accounts, records, or affairs to

the reasonable inspection or examination of the Commissioner, his Deputies, or duly appointed examiners;

(7) Has an officer who has refused upon reasonable demand to be examined under oath touching its affairs;

(8) Fails to file with the Commissioner a copy of an amendment to its charter or articles of association within 30 days after the effective date of such amendment;

(9) Has had its corporate existence dissolved or its certificate of authority revoked in the state in which it was organized;

(10) Has had all its risks reinsured in their entirety in another company, without prior approval of the Commissioner;

(11) Has made, issued, circulated, or caused to be issued or circulated any estimate, illustration, circular, or statement of any sort misrepresenting either its status or the terms of any policy issued or to be issued by it, or the benefits or advantages promised thereby, or the dividends or shares of the surplus to be received thereon, or has used any name or title of any policy or class of policies misrepresenting the true nature thereof;

(12) Has filed, caused to be filed, or failed to prevent the filing of, a statement on its behalf from an independent organization attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information; or

(13) Has filed, caused to be filed, or failed to prevent the filing of a statement on its behalf from a corporate officer attesting to its qualifications to transact business in the District for which it sought and received a certificate of authority if it knew, or should have known, that the statement was based on false, misleading, or incomplete information.

(b) The Commissioner shall not revoke or suspend the certificate of authority of any company until he has given the company not less than 30 days notice of the proposed revocation or suspension and of the grounds alleged therefor, and has afforded the company an opportunity for a full hearing; provided, that if the Commissioner shall find upon examination that the further transaction of business by the company would be hazardous to the public or to the policyholders or creditors of the company in the District, he may suspend such authority without giving notice as herein required; provided further, that in lieu of revoking or suspending the certificate of authority of any company for causes enumerated in this section, after hearing as herein provided, the Commissioner may subject such company to a penalty of not more than \$10,000 for any violation or not more than \$25,000 for intentional violations, when in his judgment he finds that the public interest would be best served by the continued operation of the company. The amount of any such penalty shall be paid by the company through the Office of the Commissioner to the Collector of Taxes of the District of Columbia. At any hearing provided by this section, the Commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely after having been administered such an oath shall be subject to the penalties of perjury.

(June 19, 1934, 48 Stat. 1131, ch. 672, ch. II, § 6; May 4, 1950, 64 Stat. 103, ch.

157, § 1; Feb. 22, 1958, 72 Stat. 20, Pub. L. 85-334, § 2; Mar. 14, 1985, D.C. Law 5-160, § 3(a), 32 DCR 39; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-190, § 2(b), 47 DCR 7261; Oct. 1, 2002, D.C. Law 14-190, § 602(b), 49 DCR 6968; Mar. 13, 2004, D.C. Law 15-105, § 65, 51 DCR 881.)

Cross references. — Administrative procedure, see § 2-501 et seq.

Credit life, accident, and health insurer violations, proceedings, see § 31-5111.

Examination of insurers, proceedings on refusal to comply, see § 31-1403.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Qualified independent certified public accountants, hearing to determine qualifications, see § 31-305.

Section references. — This section is referred to in §§ 31-2231.17 and 32-1608.

Prior Codifications. — 1981 Ed., § 35-405. 1973 Ed., § 35-405.

Effect of amendments. — D.C. Law 13-190 added subsec. (a)(12)

D.C. Law 14-190, in subsec. (a), made nonsubstantive changes to pars. (11) and (12), and added par. (13).

D.C. Law 15-105, in par. (12) of subsec. (a), validated a previously made technical correction.

Emergency legislation. — For temporary (90 day) amendment of section, see § 602(b) of Fiscal Year 2003 Budget Support Emergency Act of 2002 (D.C. Act 14-453, July 23, 2002, 49 DCR 8026).

Legislative history of Law 5-160. — Law 5-160, the "Life Insurance Amendments Reform Act of 1984," was introduced in Council and assigned Bill No. 5-471, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 20, 1984, and December 4, 1984, respectively. Signed by the Mayor on December 7, 1984, it was assigned Act No. 5-225 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Legislative history of Law 13-190. — For Law 13-190, see notes following § 35-404.

Legislative history of Law 14-190. — For Law 14-190, see notes following § 31-2502.02.

Legislative history of Law 15-105. — For Law 15-105, see notes following § 31-2402.

Editor's notes. — Office of Collector of Taxes abolished: The Office of the Collector of Taxes was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Collector of Taxes including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3, dated August 28, 1952. Reorganization Order No. 20, dated November 10, 1952, transferred the functions of the Collector of Taxes to the Finance Office. The same Order provided for the Office of the Collector of Taxes headed by a Collector in the Finance Office, and abolished the previously existing Office of the Collector of Taxes. Reorganization Order No. 20 was superseded and replaced by Organization Order No. 121, dated December 12, 1957, which provided that the Finance Office (consisting of the Office of the Finance Officer, Property Tax Division, Revenue Division, Treasury Division, Accounting Division, and Data Processing Division) would continue under the direction and control of the Director of General Administration, and that the Treasury Division would perform the function of collecting revenues of the District of Columbia and depositing the same with the Treasurer of the United States. Organization Order No. 121 was revoked by Organization Order No. 3, dated December 13, 1967, Part IVC of which prescribed the functions of the Finance Office within a newly established Department of General Administration. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Functions of the Finance Office as stated in Part IVC of Organization Order No. 3 were transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969. The collection functions of the Director of the Department of Finance and Revenue were transferred to the District of Columbia Treasurer by § 47-316 on March 5, 1981.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

CASE NOTES

Revocation of certificates.

Evidence was insufficient to support finding of Superintendent of Department of Insurance, in revoking insurer's certificate of authority to transact business, that the insurer through its principal officers caused issuance of printed material misrepresenting status of corporation

which they had organized for declared purpose of assisting senior citizens in acquiring low cost hospital insurance. D.C. Code §§ 1-1510(3)(E), 35-405. *Union Fidelity Life Ins. Co. v. District of Columbia Dep't of Ins.*, 295 A.2d 62, 1972 D.C. App. LEXIS 261 (1972).

§§ 31-4306, 31-4307. Certificate of authority — Companies required to file; failure to file; publication of summary; annual financial statement — Forms to be furnished by Superintendent. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-42, § 7(b), 40 DCR 6020.)

Prior Codifications. — 1981 Ed., §§ 35-406, 35-407.

Legislative history of Law 10-42. — Law 10-42, the "Required Annual Financial Statements and Participation in the NAIC Insurance Regulatory Information System Act of 1993," was introduced in Council and assigned Bill No. 10-129, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-77 and transmitted to both Houses of Congress for its review. D.C. Law 10-42 became effective on October 21, 1993.

Legislative history of Law 10-42. — Law 10-42, the "Required Annual Financial Statements and Participation in the NAIC Insurance

Regulatory Information System Act of 1993," was introduced in Council and assigned Bill No. 10-129, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-77 and transmitted to both Houses of Congress for its review. D.C. Law 10-42 became effective on October 21, 1993.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Editor's notes. — D.C. Law 11-268, § 10(i) (44 DCR 1730), eff. May 21, 1997, amends these sections subsequent to their repeal.

§ 31-4308. Companies or agents not to make or publish false statements. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1132, ch. 672, ch. II, § 9; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-408. 1973 Ed., § 35-408.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-4309. Representation of financial standing—All companies or agents. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1132, ch. 672, ch. II, § 10; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-409. 1973 Ed., § 35-409.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-4310. Representation of financial standing — Alien companies; violations.

(a) Every advertisement or public announcement and every sign, circular, or card issued by an alien company doing business in the District, representing its financial standing, shall exhibit as capital stock and assets only the capital stock and assets held by its United States branch, the liabilities, including therein the premium and loss reserves required by law, and the amount of surplus, and shall correspond to the next preceding verified statement made by such company to the Commissioner; provided, however, that this section shall not be deemed to prevent an alien company from furnishing to its policyholders in the District of Columbia its annual report to policyholders of its domicile. This subsection shall not apply to an alien company which maintains in the United States, as required by law, assets held in trust for the benefit of the United States policyholders in an amount not less than the sum of its required capital deposit and the amount of its outstanding liabilities arising out of its insurance transactions in the United States.

(b) Any violation of this section or § 31-4309 [repealed] shall be a misdemeanor, and any person convicted of such violation shall, for the 1st offense, be liable to a fine of not more than \$500, and for each subsequent offense shall be liable to a fine of not more than \$1,000.

(June 19, 1934, 48 Stat. 1132, ch. 672, ch. II, § 11; Dec. 5, 1963, 77 Stat. 347, Pub. L. 88-193, § 2; Sept. 7, 1966, 80 Stat. 705, Pub. L. 89-559, § 1; Aug. 8, 1968, 82 Stat. 662, Pub. L. 90-467; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-410. 1973 Ed., § 35-410.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4311. Defamatory or injurious false statements against companies. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1132, ch. 672, ch. II, § 12; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-411. 1973 Ed., § 35-411.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-4312. Commissioner authorized to issue subpoenas; enforcement.

(a) In the examination of any company as provided for in this subdivision, the Commissioner shall have power to issue subpoenas in the name of the Chief Judge of the Superior Court of the District of Columbia to compel witnesses to appear and testify and/or to produce all books, records, papers, or documents before said Commissioner.

(b) If any witness having been personally summoned shall neglect or refuse to obey the subpoena issued as herein provided, then and in that event the Commissioner may report that fact to the Superior Court of the District of Columbia, or one of the judges thereof, and said Court, or any judge thereof, hereby is empowered to compel obedience to said subpoena to the same extent as witnesses may be compelled to obey the subpoenas of that Court.

(June 19, 1934, 48 Stat. 1133, ch. 672, ch. II, § 13; June 25, 1936, 49 Stat. 1921, ch. 804; June 25, 1948, 62 Stat. 991, ch. 646, § 32(a), (b); May 24, 1949, 62 Stat. 107, ch. 139, § 127; July 29, 1970, 84 Stat. 572, Pub. L. 91-358, title I, § 155(c)(37)(A); May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-412. 1973 Ed., § 35-412.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4313. Enforcement of Commissioner's orders or actions.

The Commissioner may, through the Corporation Counsel of the District, invoke the aid of any court of competent jurisdiction to enforce any order made or action taken by him in pursuance of law.

(June 19, 1934, 48 Stat. 1133, ch. 672, ch. II, § 14; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-413. 1973 Ed., § 35-413.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4314. False statements in application for policy.

The falsity of a statement in the application for any policy of insurance shall not bar the right to recovery thereunder unless such false statement was made with intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the company.

(June 19, 1934, 48 Stat. 1133, ch. 672, ch. II, § 15; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Form and contents of insurance contracts, see §§ 31-4703, 31-4712.

Industrial policies, special provisions, see § 31-4801 et seq.

Prior Codifications. — 1981 Ed., § 35-414. 1973 Ed., § 35-414.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

CASE NOTES

ANALYSIS

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Admissibility of evidence.

In action on life policy defended on ground of misrepresentations in application, objection to testimony of physician who attended insured as to what he treated insured for on ground of privilege was properly sustained. D.C. Code 1940, § 35-414. *Metropolitan Life Ins. Co. v. Adams*, 37 A.2d 345, 1944 D.C. App. LEXIS 168 (Cr.App. 1944).

Application terms.

Under District of Columbia law, insurer could not successfully interpose defense of misstatement of, or omission to state, material medical facts in application form, where applicant, at request of insurer's agent, signed ap-

plication form in blank, applicant and his wife orally gave truthful and full answers to questions on application form as they were propounded by the agent, the agent himself recorded one or more material misstatements of fact on the application form or omitted to record material information, and neither the applicant nor his wife knew of the agent's entry on the application form of any such misstatement or of the agent's omission of any material information, or read the application form either before its submission to insurer, or after policy was issued and returned to insured with application form in reduced form attached to and made part of the issued policy. D.C. Code § 35-414. *Blair v. Prudential Ins. Co.*, 472 F.2d 1356, 1972 U.S. App. LEXIS 6094 (C.A.D.C. 1972).

The effect of statute enacted to prevent innocent and immaterial misrepresentations in application from avoiding insurance cannot be escaped by device of contracting to the contrary or labeling a contractual attempt to do so a condition to the attaching of the risk. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Where application for life policy contained clause that policy should not take effect until received by insured and full first premium thereon was paid while conditions material to risk represented by statements in application remain same as described therein, and insurer contended that the clause made truth of state-

ments conditions precedent to attaching of risk, the so-called "condition precedent" was invalid to extent that it was more broadly effective than permitted by statute regarding false statements in application for insurance. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Parties may validly agree that life insurance shall not attach unless insured is in good health when the policy is issued. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

Insurer is entitled to truthful responses to all questions on an insurance application so that it may correctly evaluate the risk and determine whether the applicant meets its underwriting standards. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Under District of Columbia law, insurer has a right to rely on statements made in the insurance application. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Under District of Columbia law, insurer, which sought declaration that material falsehoods in insured's application for commercial general liability (CGL) policy defeated coverage under policy for third-party actions against insured, had right to rely on statements in insurance application and to truthful responses to application's questions, and did not have to conduct independent investigation of food and liquor sales figures upon which it relied in issuing policy after learning that prior insurer had cancelled its policy based on size of facility's dance floor, despite contention that such information gave reasonable notice that facility, which was nightclub, was not traditional restaurant, as suggested by application's statement that facility was restaurant/bar with dance floor. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Insured has duty to read policy application which he signs, or, if necessary, to have it read to him and to report any misrepresentations or omissions to the insurer; he is held to know contents of his application and is bound thereby, regardless of whether he has actual knowledge of such at time he signed the form. D.C. Code § 35-414. *Metropolitan Life Ins. Co. v. Johnson*, 363 A.2d 984, 1976 D.C. App. LEXIS 381 (1976).

Life policy, which provided that statements made in an application for insurance "shall be deemed representations and not warranties," did not require insurer to show that applicant's false statement, which was conceded to materially affect the risk assumed, was made with

intent to deceive. D.C. Code § 35-414. *Hill v. Prudential Ins. Co.*, 315 A.2d 146, 1974 D.C. App. LEXIS 356 (1974).

Burden of proof.

Where insurer charged that insured prior to application for life policy had had duodenal ulcer, abnormal blood pressure, dizziness, loss of consciousness and kidney disease, and that in application he falsely denied their existence, to avoid life policy for material misrepresentation on account of answers, insurer had burden of proving one or more of them false. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Under District of Columbia law, proof that an application for insurance contains a false statement which materially affects the acceptance of risk or hazard assumed by the insurer is sufficient to defeat a claim under the policy. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Under District of Columbia law, insurer seeking to cancel policy must prove, by a preponderance of clear and satisfactory evidence, that statement claimed to be false on application was, in fact, false and that untrue statement was material, either by showing that it affected insurer's risk of loss in issuing policy or that statement was made with intent to deceive. D.C. Code 1981, § 35-414. *National Union Fire Ins. Co. v. Mason, Perrin & Kanovsky*, 765 F. Supp. 15, 1991 U.S. Dist. LEXIS 12678 (1991).

Proof that an application for insurance contains a false statement which materially affects acceptance of risk or hazard assumed is sufficient to defeat a claim under the policy. D.C. Code § 35-414. *Hill v. Prudential Ins. Co.*, 315 A.2d 146, 1974 D.C. App. LEXIS 356 (1974).

Provision of D.C. Code stating that falsity of a statement in application for any policy shall not bar right to recovery thereunder unless such false statement was made with intent to deceive or unless it materially affected either acceptance of risk or hazard assumed by insurer is without ambiguity, and did not require life insurer to prove that applicant's false statement, which was conceded to materially affect the risk assumed, was made with intent to deceive. D.C. Code § 35-414. *Hill v. Prudential Ins. Co.*, 315 A.2d 146, 1974 D.C. App. LEXIS 356 (1974).

Under statute providing that falsity of statement in application shall not bar right to recovery under policy unless statement was made with intent to deceive or unless it materially affected either acceptance of risk or hazard assumed by insurer, insurer has burden of proof as to elements indicated in order to avoid

life policy. D.C. Code 1940, § 35-414. *Metropolitan Life Ins. Co. v. Adams*, 37 A.2d 345, 1944 D.C. App. LEXIS 168 (Cr.App. 1944).

Construction and application.

Statute providing that falsity of statement in application shall not bar right to recovery under policy unless statement was made with intent to deceive or unless it materially affected either acceptance of risk or hazard assumed by insurer, was intended to prevent innocent and immaterial misrepresentations in application from avoiding insurance. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

The purpose of statute regarding effect of false statement in application for insurance was to nullify contractual provisions contrary to its terms, and therefore a so-called condition precedent is invalid to extent that it is more broadly effective than the statute allows. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

District of Columbia statute addressing false statements in applications for insurance policies did not apply to insurer's denial of coverage for legal malpractice claim against law firm under firm's claims-made professional liability policy, which was based upon exclusion that barred coverage for claim where insured, prior to policy's inception date, had basis to believe that act or omission underlying claim might reasonably be expected to be the basis of a claim, rather than upon any assertion that firm made false statement in its insurance application, causing policy to be void or not in effect. *Ross v. Cont'l Cas. Co.*, 420 B.R. 43, 2009 U.S. Dist. LEXIS 112048 (2009), affirmed by 393 Fed. Appx. 726, 2010 U.S. App. LEXIS 19826 (D.C. Cir. 2010).

Deceptive intent.

Where application for life policy stated that applicant had not consulted or been treated by physician within five years, fact that applicant had twice consulted physicians for pain in the abdomen and died about a year later of cancer of the stomach did not avoid the policy, where evidence indicated that such pains were diagnosed as acute indigestion, not serious, and there was no showing that insured had such consultations in mind when he applied. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

If applicant for life policy makes statements of medical history which are material, and which he knows to be false, the policy is avoided without proof of conscious design to defraud. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

Decedent's negative answers in his application for life insurance and his application for reinstatement to questions whether he "regularly used" or "is currently using" marijuana were false, those statements were made with intent to deceive insurer into issuing a policy of insurance on decedent's life and statements related to material matter, and therefore, recovery under policy was barred under District of Columbia code. D.C. Code 1981, § 35-414. *Johnson v. Prudential Ins. Co.*, 589 F. Supp. 30, 1983 U.S. Dist. LEXIS 10284 (1983), affirmed without opinion by 744 F.2d 878, 240 U.S. App. D.C. 254 (1984).

Estoppel.

Under appropriate circumstances, principles of equitable estoppel may preclude statutory defense by insurer of misstatement in application for policy. D.C. Code § 35-414. *Metropolitan Life Ins. Co. v. Johnson*, 363 A.2d 984, 1976 D.C. App. LEXIS 381 (1976).

Where insured signed application for life policy and received copy which remained in his possession until his death, insured did not provide agent with information regarding his health, agent was not aware of insured's poor physical condition and agent did not deliberately record false information or induce or coerce insured to sign form without reading it or without disclosing pertinent information about his health, insured was inexcusably negligent in failing to become aware of responses on application and was chargeable with knowledge of all that reading should have revealed; thus doctrine of equitable estoppel could not be invoked to excuse insured's failure to read the application. D.C. Code § 35-414. *Metropolitan Life Ins. Co. v. Johnson*, 363 A.2d 984, 1976 D.C. App. LEXIS 381 (1976).

False statements.

Applicant's negative response to question in life policy's application as to whether he had in past five years been treated for "any sickness, disease or injury" was false as a matter of law, thereby making policy void under D.C. Code section, even though application conditioned response "to the best of [the applicant's] knowledge and belief," where medical records and testimony revealed history of alcohol-related problems and several occasions during period in which applicant had sought medical attention for severe chest pains, as his negative response was in direct conflict with human experience. D.C. Code 1981, § 35-414. *Skinner v. Aetna Life & Casualty*, 804 F.2d 148, 1986 U.S. App. LEXIS 32868 (C.A.D.C. 1986).

To avoid life policy under statute regarding effect of false statements in application, the statement must be both false and made with intent to deceive or material to risk or its acceptance, unless possibly both intent to de-

ceive and materiality are required in addition to falsity. D.C. Code 1940, § 35-414. Prudential Ins. Co. of America v. Saxe, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Genuine issues of material fact as to whether insured's false statement on his life insurance policy application, which did not reveal that he had filled many prescriptions for a variety of medications, including pain killers, muscle relaxers, sleep aids, and antidepressants, within the five years preceding his application, was material to the insurer's decision as to whether and at what rate to insure, and thus whether insurer had right to rescind the policy under District of Columbia law, precluded summary judgment on beneficiary's breach of contract action challenging insurer's refusal to pay under the policy following insured's death. Thorpe v. Banner Life Ins. Co., 632 F.Supp.2d 8, 2009 U.S. Dist. LEXIS 60122 (2009).

Under District of Columbia law, commercial general liability (CGL) insurer owed duty to insured to cover settlement costs in third-party personal injury action against insured, even though insurer believed that coverage was voided under policy due to false statement in insurance application. Burlington Ins. Co. v. Okie Dokie, Inc., 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Insurance broker acted as nightclub owner's agent when broker completed owner's application for commercial general liability (CGL) policy, and therefore owner was subject to consequences of false statements in application respecting nightclub's food and liquor sales, even if broker was responsible for those statements, for purposes of insurer's claim that District of Columbia statute defeated coverage under policy for third-party personal injury actions against nightclub owner based on application's false statements. Burlington Ins. Co. v. Okie Dokie, Inc., 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Nightclub owner's application for commercial general liability (CGL) policy contained false statement, for purposes of insurer's claim seeking declaration that District of Columbia statute defeated coverage under policy with respect to third-party actions against nightclub owner based on false statement in application, inasmuch as application indicated that nightclub's liquor sales were \$1,000,000 and food sales were \$3,000,000, whereas owner's principal indicated that those numbers were not representative of nightclub's sales. Burlington Ins. Co. v. Okie Dokie, Inc., 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Where the misrepresentation in a life insurance policy would affect the company's acceptance of the risk, or where the misrepresentation is made with intent to deceive, there need be no causal relationship between the misrepresented matter and the insured's death. D.C.

Code § 35-414. Jones v. Prudential Ins. Co., 388 A.2d 476, 1978 D.C. App. LEXIS 532 (1978).

Instructions.

In action on life policy defended on ground of misrepresentations in application which denied knowledge of heart trouble and medical attendance, instructions which submitted only issue as to whether there were misrepresentations as to heart trouble, and which failed to submit issue as to whether there were misrepresentations in regard to medical attendance, were erroneous. D.C. Code 1940, § 35-414. Metropolitan Life Ins. Co. v. Adams, 37 A.2d 345, 1944 D.C. App. LEXIS 168 (Cr.App. 1944).

Jury questions.

Where evidence was conflicting regarding whether insured's hospitalization was genuine or fictitious, whether misstatements in application for life policy regarding hospitalization and consultation of physician were made with intent to deceive, and were material to hazard assumed or false within meaning of statute regarding effect of false statements in application was for jury. D.C. Code 1940, § 35-414. Prudential Ins. Co. of America v. Saxe, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Where evidence was conflicting as to whether hospitalization of insured and hospital record disclosing diagnosis of duodenal ulcer were genuine or were fictitious, whether insured's answers in application for life policy which failed to disclose hospitalization and diagnosis were material to acceptance of risk was for jury. D.C. Code 1940, § 35-414. Prudential Ins. Co. of America v. Saxe, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

Law governing.

Under District of Columbia law, provision in life insurance policy application that policy would not take effect unless applicant was actually in the state of health and insurability represented in the application was invalid and could not be used to rescind policy of insured on grounds that he failed to disclose his history of prescription drug use and various medical consultations; under condition, any misstatement, whether made in good or bad faith and whether material or immaterial to insurer, would render the policy void, thereby nullifying protections afforded to insured in District of Columbia Code prohibiting insurer from voiding policy unless applicant's misrepresentations were made with the intent to deceive or were material to insurer's decision making process. Thorpe v. Banner Life Ins. Co., 632 F.Supp.2d 8, 2009 U.S. Dist. LEXIS 60122 (2009).

District of Columbia law governed insurer's claim against insured for unjust enrichment, inasmuch as insured received in the District of Columbia the alleged benefit from commercial

general liability (CGL) policy issued in reliance upon materially false statement in insurance application. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Material matters.

Estate of basketball player suing agent for failure to procure life insurance policy did not raise triable issue of fact as to whether insurance coverage would have been available in light of player's use of cocaine; estate's evidence that some life insurance companies did not inquire as to whether applicant was drug user at some stages of the application and approval procedure did not adequately rebut agent's evidence that no insurer would have failed to inquire about drug usage at some point in the process and would have declined to extend coverage if usage was admitted, or that any policy would have been void if applicant falsely represented he did not use drugs. *Bias v. Advantage Int'l, Inc.*, 905 F.2d 1558, 1990 U.S. App. LEXIS 9607 (C.A.D.C. 1990), writ of certiorari denied by 498 U.S. 958, 111 S. Ct. 387, 112 L. Ed. 2d 397, 1990 U.S. LEXIS 5610, 59 U.S.L.W. 3344 (1990).

Under both District of Columbia and Maryland law, a material misrepresentation materially affecting the hazard assumed by an insurer and its decision to accept the risk of insuring the applicant is ground for abrogating the policy of insurance, even if the misrepresentation is unintentional. D.C. Code § 35-414; Code Md.1957, art. 48A, § 374. *Blair v. Inter-Ocean Ins. Co.*, 589 F.2d 730, 1978 U.S. App. LEXIS 6803 (C.A.D.C. 1978).

Where life insurance applicant, who had recently been diagnosed as suffering from cirrhosis of the liver, answered "no" to question on life insurance application as to whether the applicant had ever had or consulted a physician concerning any liver disorder and where, in addition to concealing the diagnosis, the applicant, in response to an inquiry as to the details of any hospitalization during the past five years, neglected to mention six days that he had spent in hospital only four months before applying for insurance, at which time the cirrhosis was diagnosed, and where it was clear that had the applicant not misrepresented the condition of his health, no policy would have been issued to him, insurer was not liable to pay proceeds of policy. D.C. Code § 35-414; Code Md.1957, art. 48A, § 374. *Blair v. Inter-Ocean Ins. Co.*, 589 F.2d 730, 1978 U.S. App. LEXIS 6803 (C.A.D.C. 1978).

Misrepresentation by beneficiary, in his application for a life policy on his month-old daughter of fact that he had applied to another insurer for a similar policy, even if participated in by insurer's agent, was material and constituted a valid defense to recovery on the policy.

D.C. Code 1951, § 35-414; Insurance Law N.Y. § 147. *Jannenga v. Nationwide Life Ins. Co.*, 288 F.2d 169, 1961 U.S. App. LEXIS 5141 (C.A.D.C. 1961).

Test of materiality of a statement in an insurance application is whether the representation would reasonably influence insurer's decision as to whether it should insure. D.C. Code 1951, § 35-414; Insurance Law N.Y. § 147. *Jannenga v. Nationwide Life Ins. Co.*, 288 F.2d 169, 1961 U.S. App. LEXIS 5141 (C.A.D.C. 1961).

A misstatement in application for life policy to be "material to hazard assumed" within statute regarding effect of misstatements in application must be shown in some way to have affected the hazard assumed or contributed to the loss in a substantial manner. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

An erroneous statement in an application for change of beneficiary which does not relate to a material matter and is not made with intent to deceive, does not avoid a life policy. D.C. Code Supp. V, T. 5, § 217m. *Carter v. Provident Ins. Co.*, 122 F.2d 960, 1941 U.S. App. LEXIS 3127 (1941).

The erroneous description of new beneficiary as "common-law wife" in insured's application for change of beneficiary did not relate to a "material matter" and did not avoid industrial life policy which insured himself had taken out, where there was no evidence that insured used the term with intent to deceive, since a beneficiary in a policy taken out by insured need not have an insurable interest. D.C. Code Supp. V, T. 5, § 217m. *Carter v. Provident Ins. Co.*, 122 F.2d 960, 1941 U.S. App. LEXIS 3127 (1941).

Change of designation "wife" to "friend" in indorsement changing beneficiary of industrial life policy was an "innocent and immaterial correction" which could not be relied on as a defense in action on policy under policy provision that policy should be void if any erasure or alteration was made thereon not authorized by insurer; "erasure" involving "obliteration", and "alteration" involving "material change". *Carter v. Provident Ins. Co.*, 122 F.2d 960, 1941 U.S. App. LEXIS 3127 (1941).

An applicant for life policy need not disclose the fact of consulting physician for slight or temporary ailments such as ordinary cold, inability to sleep, constipation, headache, or the like. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

To avoid life policy on ground of false representation, answer in application must not only have been untrue, but must have been with reference to a material matter. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

Failure to disclose fact that insured has obtained other insurance between date of application and date of policy is no defense in action on life policy, at least so long as other insurance is not shown to be of such amount as to affect the risk. *Kaplan v. Manhattan Life Ins. Co. of New York*, 109 F.2d 463, 1939 U.S. App. LEXIS 2477 (1939).

Genuine issue of material fact as to whether insurance broker failed to notify insurer that nightclub owner's estimated liquor sales figure in its application for liquor liability insurance had changed from 40% of total sales to 25% of total sales and that its employee had relied on the 25% figure when completing general commercial liability application precluded summary judgment on insurer's negligent misrepresentation claim under District of Columbia law. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 439 F.Supp.2d 124, 2006 U.S. Dist. LEXIS 47979 (2006).

Under District of Columbia law, a false statement on an insurance application is "material" if it concerns a matter which would reasonably cause the insurer to consider either not issuing the policy, because of increased risk, or issuing the policy with an increased premium. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

False sales figures for food and liquor listed on nightclub owner's application for commercial general liability (CGL) policy materially affected insurer's decision to issue policy, entitling insurer to declaration that coverage under policy for third-party actions against nightclub owner were barred by District of Columbia statute indicating that materially false statement in insurance application barred right to recovery under policy; insurer submitted binder to its agent which showed that insurer considered level of alcohol sales to be important factor in its coverage decision, and stated that it was not interested in owner's account if liquor sales were higher than 25 percent of total sales. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Under District of Columbia law, insured's failure to disclose her prior alcoholism treatment on application for life policy was a material misrepresentation permitting insurer to invalidate policy, where insurer would have denied application if medical history had been disclosed. D.C. Code 1981, § 35-414. *Hood v. Prudential Ins. Co.*, 758 F. Supp. 764, 1991 U.S. Dist. LEXIS 2992 (1991).

Test of materiality, as that term is used in section of District of Columbia code barring recovery under insurance policy for false statement in application, is whether representation would reasonably influence insurer's decision as to whether it should insure applicant. D.C. Code 1981, § 35-414. *Johnson v. Prudential*

Ins. Co., 589 F. Supp. 30, 1983 U.S. Dist. LEXIS 10284 (1983), affirmed without opinion by 744 F.2d 878, 240 U.S. App. D.C. 254 (1984).

Misrepresentation of the insured, who died in a drug-related homicide, in life insurance policy reinstatement application that she did not use narcotics or sedatives habitually and had never been treated for a drug habit was material to the issuance of the policy as a matter of law, in view of deputy medical examiner's testimony delineating the health hazards faced by habitual heroin users. D.C. Code § 35-414. *Jones v. Prudential Ins. Co.*, 388 A.2d 476, 1978 D.C. App. LEXIS 532 (1978).

Where insured in application for insurance stated that he had visited doctor only once in year preceding application and that he did not have high blood pressure but insured, in fact, was being treated for high blood pressure and had visited doctor seven or eight times in year preceding application and where insurer would not have issued policy if it had been apprised of insured's true medical condition, insurer was entitled to cancel insured's coverage under group health and accident disability policy. D.C. Code § 35-414. *Westhoven v. New England Mut. Life Ins. Co.*, 384 A.2d 36, 1978 D.C. App. LEXIS 435 (1978).

Where had insurer known that applicant for life policy had suffered and was suffering from cerebral thrombosis and cerebral vascular accidents it would have rejected application for policy, recovery from insured was barred by statute providing that falsity of statement in application shall not bar right to recovery unless it materially affected either acceptance of risk or hazard assumed by company. D.C. Code § 35-414. *Metropolitan Life Ins. Co. v. Johnson*, 363 A.2d 984, 1976 D.C. App. LEXIS 381 (1976).

Misstatement in application for insurance policy, to be material to hazard assumed, must be shown in some way to have affected it or contributed to the loss, and in substantial manner. D.C. Code § 35-414. *Haubner v. Aetna Life Ins. Co.*, 256 A.2d 414, 1969 D.C. App. LEXIS 288 (App. 1969).

Facts suppressed by life insurance applicant concerning her consultations with and examinations by physicians prior to time she applied for policy and her previous history of cancer affected in substantial manner hazard assumed by insurer and would have influenced insurer's decision to insure her, and such false statements by insured were material to issuance of policy. D.C. Code § 35-414. *Haubner v. Aetna Life Ins. Co.*, 256 A.2d 414, 1969 D.C. App. LEXIS 288 (App. 1969).

Insured's failure to reveal information to life insurer that she had been consulting with physicians at time of policy application and that she had previous history of cancer constituted sufficient cause to justify insurer's refusal to

pay proceeds of policy. D.C. Code § 35-414. *Haubner v. Aetna Life Ins. Co.*, 256 A.2d 414, 1969 D.C. App. LEXIS 288 (App. 1969).

Where insured falsely stated in application for life policy that he had not been treated by physicians, though he had in fact been treated by three physicians for a heart disease, such misrepresentations materially affected acceptance of the risk and the hazard assumed by the insurer and precluded recovery on the policy by beneficiary. D.C. Code 1940, § 35-414. *Kaitlin v. Metropolitan Life Ins. Co.*, 65 A.2d 188, 1949 D.C. App. LEXIS 162 (Cr.App. 1949).

Remedies.

Insured received benefit of coverage under commercial general liability (CGL) policy even though coverage was barred under District of Columbia statute, due to materially false statement in insurance application, when insurer paid to defend and settle third-party personal injury claims against insured, and therefore insurer was entitled to indemnification from insured under theory of unjust enrichment under District of Columbia law. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Insurer under commercial general liability (CGL) policy issued in reliance on materially false statements in insured's application could obtain declaratory relief under District of Columbia statute providing that false statement in application barred right to recovery under insurance policy, notwithstanding that insurer did not reserve right to immediate cancellation and indicated, in binder, that it would not renew policy if audit revealed that insured's liquor sales were higher than reported on application, thereby allegedly choosing non-renewal as its exclusive remedy. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 398 F.Supp.2d 147, 2005 U.S. Dist. LEXIS 25162 (2005).

Sufficiency of evidence.

Where insurer sought to avoid liability on life policy on ground that insured, prior to application, had had duodenal ulcer, abnormal blood pressure, dizziness, loss of consciousness, kidney disease, and in application falsely denied existence thereof, evidence sustained verdict against insurer. D.C. Code 1940, § 35-414. *Prudential Ins. Co. of America v. Saxe*, 134 F.2d 16, 1943 U.S. App. LEXIS 3485 (1943).

In action to recover on life insurance policy, the jury could not reasonably have found that the insured, who died in a drug-related homicide, had not been addicted to heroin prior to the time she filed application to reinstate the policy. D.C. Code § 35-414. *Jones v. Prudential Ins. Co.*, 388 A.2d 476, 1978 D.C. App. LEXIS 532 (1978).

Summary judgment.

Genuine issues of material fact as to whether insured's false statement on his life insurance policy application, that within the previous ten years he had not been treated or diagnosed by a member of the medical profession as having backache, was material to the insurer's decision as to whether and at what rate to insure, and thus whether insurer had right to rescind the policy under District of Columbia law, precluded summary judgment on beneficiary's breach of contract action challenging insurer's refusal to pay under the policy following insured's death. *Thorpe v. Banner Life Ins. Co.*, 632 F.Supp.2d 8, 2009 U.S. Dist. LEXIS 60122 (2009).

Genuine issues of material fact as to whether liability insurer reasonably relied on food to liquor sales ratio disclosed in nightclub owner's insurance application after owner's previous insurer disclosed a different ratio to employee of insurer's authorized agent and whether insurer was aware that the sales figures contained in the application were estimates precluded summary judgment on issue of whether false statement in the application barred recovery under policy pursuant to District of Columbia law. *Burlington Ins. Co. v. Okie Dokie, Inc.*, 439 F.Supp.2d 124, 2006 U.S. Dist. LEXIS 47979 (2006).

Waiver.

Even if life insurer's doctor should have known that tumor causing removal of breast in 1953 was malignant and recurrence of malignancy in future was definite possibility, such did not operate as waiver by insurer of defense based on false statements allegedly contained in application for policy, where applicant concealed information, concerning present consultations, that was clearly material to issuance of life insurance policy. D.C. Code § 35-414. *Haubner v. Aetna Life Ins. Co.*, 256 A.2d 414, 1969 D.C. App. LEXIS 288 (App. 1969).

§ 31-4315. Deposit of securities by companies desiring to transact business — Amount; deposits outside District.

(a) Every company desiring to transact business in the District shall, as a prerequisite to the issuance of a certificate of authority, deposit, as herein provided, approved securities of not less than \$100,000 market value. In the

case of domestic companies, such deposit shall be made in the District as prescribed under § 31-4316; provided, that the deposit of every domestic company heretofore organized under the provisions of the laws of the District or other act of Congress may, in the discretion of the Commissioner, be limited: (1) For stock companies, to an amount equal to the capital stock outstanding on June 19, 1934; and (2) for nonstock companies, to such amount as in the opinion of the Commissioner would be required from stock companies of comparable size. In no case shall the deposit of a domestic company be less than \$25,000 in value. In the case of foreign or alien companies, the deposit may be made as provided under § 31-4316, or may be made with the supervising official of any state, territory, or insular possession of the United States authorized to accept such deposit, which shall be held for the benefit of all policyholders.

(b) In the case of a deposit made with an official outside the District, a certificate of deposit from said official shall be filed with the Commissioner, showing the character of the deposit, before a certificate of authority to transact business in the District may be issued, and, if the securities so deposited are not of the class authorized by this subdivision for investments of companies, the Commissioner may require an additional deposit in approved securities.

(June 19, 1934, 48 Stat. 1133, ch. 672, ch. II, § 16; May 20, 1940, 54 Stat. 217, ch. 204; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730; Mar. 24, 1998; D.C. Law 12-81, § 22(b), 45 DCR 745.)

Cross references. — Reserves, see § 31-5201.

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-415.
1973 Ed., § 35-415.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4316. Deposit of securities by companies desiring to transact business — Type of securities allowed; officials responsible for safekeeping; collection of income; substitution; decline in value.

(a) When any company is required by this subdivision to make a deposit in the District, such deposit shall be in securities of the class authorized by this subdivision for investments of companies, and shall be delivered by the company to the Executive Secretary of the District and the Auditor of the District, who shall receive and hold the same subject to the lawful orders of the Commissioner, and who shall be responsible for the safekeeping of all securities deposited or delivered under the authority of this section. The company shall have the right to collect the income on deposited securities so long as it

continues solvent and complies with the laws of the United States and of the District, and it shall have the right to substitute for such securities other securities, provided such substituted securities are of the character, amount, and value required by this section, and are approved by the Commissioner; provided, that not less than \$25,000 of such deposit shall at all times consist of bonds or other evidences of indebtedness of the United States or of any state of the United States, or of any county or incorporated city of any state of the United States, and that securities of a class different from such bonds or other evidences of indebtedness shall not in any case be accepted for deposit except with the specific approval of and at values determined by the Commissioner.

(b) If the value of securities deposited by any company shall decline, the Commissioner may require the company to make a further deposit, in order that the amount and value of the deposit required by this subdivision shall at all times be maintained.

(June 19, 1934, 48 Stat. 1134, ch. 672, ch. II, § 17; May 20, 1940, 54 Stat. 217, ch. 204; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Reserves, see § 31-5201.

Section references. — This section is referred to in §§ 31-3503 and 31-4315.

Prior Codifications. — 1981 Ed., § 35-416. 1973 Ed., § 35-416.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Transfer of Functions. — Reorganization Order No. 23, dated December 30, 1952, transferred the functions relating to the delivery of securities required to be deposited by insurance companies transacting business in the District of Columbia from the Secretary of the Board of Commissioners and the Auditor of the District to the Internal Audit Officer or his deputy and the Disbursing Officer or his deputy, Department of General Administration. The Disbursing Office was established in the Finance Office of the Department of General Administration by Reorganization Order No. 20, dated November 10, 1952. Reorganization Order No. 20 was superseded by Organization Order No. 121, dated December 12, 1957, which placed disbursing functions in the Treasury Division of the Office of the Finance Officer. Organization Order No. 121 was revoked by Organization Order No. 3, dated December 23, 1967, under Part IVC of which disbursing functions were continued in the Treasury Division of the Finance Office. These functions were subsequently transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969.

Editor's notes. — Office of Secretary to Board of Commissioners abolished: The Office

of the Secretary to the Board of Commissioners of the District of Columbia was abolished and the functions thereof transferred to the Board of Commissioners by Reorganization Plan No. 5 of 1952. Reorganization Order No. 41 of the Board of Commissioners, dated June 23, 1953, issued pursuant to that Plan, established as part of the Executive Office of the Board of Commissioners, under the direction and control of the Board, an Office of the Secretary to the Board of Commissioners to perform ministerial duties for the Board. The Order described the purpose and functions of the Office of Secretary, and provided that the functions and positions of the previously existing Office of the Secretary to the Board be transferred to the new Office, and that the previously existing Office of the Secretary be abolished. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Organization Order No. 2 of the Commissioner, dated December 13, 1967, as amended, established within the Executive Office of the Commissioner a Secretariat headed by an Executive Secretary. The Order transferred to the Secretariat certain functions, including the duties, powers, and authorities of all officers and employees performing such functions and assigned to the Office of the Secretary as it existed immediately prior to December 13, 1967, and revoked all other orders inconsistent therewith.

Office of Auditor abolished: The Office of the Auditor of the District of Columbia was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Auditor

including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3 of the Board of Commissioners, dated August 28, 1952. Reorganization Order No. 19, dated November 10, 1952, established in the Department of General Administration an Internal Audit Office headed by an Internal Office Auditor. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Reorganization Orders No. 3 and 19 were revoked by Organization Order No. 3 of the Commissioner of the District of Columbia, dated December 13, 1967. Parts III and IVB of the latter Order established, within the newly created Department of General Administration, an Internal Audit Office headed by an Internal Audit Officer and prescribed the functions thereof. These functions were subsequently transferred to the Director of the Department of Finance and

Revenue by paragraph 4 of Commissioner's Order No. 69-96, dated March 7, 1969. Part IVB of Organization Order No. 3 and that portion of paragraph 4 of Commissioner's Order No. 69-96 pertaining to a transfer of audit functions to the Department of Finance and Revenue, were revoked by Organization Order No. 33, dated July 14, 1972. The latter Order established an Office of Municipal Audit and Inspection and prescribed the functions thereof. Organization Order No. 50, dated December 31, 1974, established the Office of Budget and Management Systems, and transferred to that Office the functions of the Office of Municipal Audit and Inspection. The Office of Budget and Management Systems was replaced by Mayor's Order 79-5, dated January 2, 1979, which Order established the Office of Budget and Revenue Development.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4317. Deposit of securities by companies desiring to transact business — Withdrawal upon discontinuance of business or reinsurance.

(a) When a company determines to discontinue its business or to cease to do business in the District and desires to withdraw its deposit made in the District pursuant to this subdivision the Commissioner shall, upon the application of the company, and at its expense, give notice of such intention in a newspaper of general circulation in the District once a week for 3 consecutive weeks. After such publication he shall deliver to such company or its assigns the securities so deposited when he is satisfied upon examination and investigation made by him or under his authority and upon the oaths of the president and secretary or other chief officers of the company that all debts and liabilities of every kind due and to become due which the deposit was made to secure are paid and extinguished; provided, that the Commissioner may require any company so withdrawing from the District to furnish bond to cover any undisclosed or contingent liabilities.

(b) Upon a company being wholly reinsured the Commissioner may deliver to it or to its assigns all securities deposited by it upon compliance with the following condition: The reinsuring company shall assume and agree to discharge all liabilities of every kind due and to become due which the deposit of the reinsured company was made to secure. Such reinsuring company shall have a deposit in the District or with some state official in the United States in securities recognized by this law as lawful investments of the company in an amount and value not less than the deposit required of the reinsured company. The deposit of the reinsuring company shall be such that it will subsist for the security of the obligations of the reinsured company assumed by the reinsuring company. The Commissioner shall give notice of such reinsurance agreement and of the application for the deposit once a week for 3 consecutive weeks in a

newspaper of general circulation in the District before the delivery of such securities to the reinsuring company.

(June 19, 1934, 48 Stat. 1134, ch. 672, ch. II, § 18; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Reserves, see § 31-5201.

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-417. 1973 Ed., § 35-417.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§§ 31-4318 Examinations; reports; expenses. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-49, § 9(b), 40 DCR 6110.)

Prior Codifications. — 1981 Ed., § 35-418.

Legislative history of Law 10-49. — Law 10-49, the "Law on Examinations Act of 1993," was introduced in Council and assigned Bill No. 10-131, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings

on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-94 and transmitted to both Houses of Congress for its review. D.C. Law 10-49 became effective on October 21, 1993.

§§ 31-4319 to 31-4321. Superintendent authorized to take over companies; grounds; procedure; liquidation; special agents and employees; rules and regulations; reports and bonds; companies deemed insolvent; reinsurance by Superintendent. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-35, § 59(a), 40 DCR 5773.)

Prior Codifications. — 1981 Ed., §§ 35-419 to 35-421.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 7(b) of Insurance Omnibus Temporary Amendment Act of 1993 (D.C. Law 10-76, March 17, 1994, law notification 41 DCR 1626).

Legislative history of Law 10-35. — Law 10-35, the "Insurers Rehabilitation and Liquidation Act of 1993," was introduced in Council and assigned Bill No. 10-123, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-68 and transmitted to both Houses of Con-

gress for its review. D.C. Law 10-35 became effective on October 15, 1993.

Legislative history of Law 10-103. — Law 10-103, the "Insurance Omnibus Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-394, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on January 4, 1994, and February 1, 1994, respectively. Signed by the Mayor on February 17, 1994, it was assigned Act No. 10-191 and transmitted to both Houses of Congress for its review. D.C. Law 10-103 became effective on April 26, 1994.

Editor's notes. — D.C. Law 10-76 and D.C. Law 10-103 purported to amend former § 35-419 1981 Ed. by rewriting (a)(4).

§ 31-4322. Valuation of securities. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1137, ch. 672, ch. II, § 23; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 22(c), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(e)(1), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-422. 1973 Ed., § 35-422.

For legislative history of D.C. Law 11- (Act 11-524), see Historical and Statutory Notes following § 31-4301.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-4301.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

§ 31-4323. Service of process; appointment of Superintendent as attorney of companies; violations. [Repealed].

Repealed.

(Mar. 21, 1995, D.C. Law 10-233, § 12, 42 DCR 24.)

Prior Codifications. — 1981 Ed., § 35-423.

Legislative history of Law 10-233. — Law 10-233, the "Insurers Service of Process Act of 1994," was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

§ 31-4324. Political contributions prohibited; immunity of witnesses in proceedings in regard to violations. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1138, ch. 672, ch. II, § 25; Mar. 8, 2007, D.C. Law 16-232, § 205(a)(2), 54 DCR 368.)

Prior Codifications. — 1981 Ed., § 35-424. 1973 Ed., § 35-424.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

§§ 31-4325 to 31-4328. General agents, agents, or solicitors; issuance, expiration and renewal of required license; exceptions; termination of employment; information provided Superintendent deemed privileged; suspension or revocation of licenses; grounds; hearing and appeal; alternative penalty; judicial appeals from rulings of Superintendent; procedure; liability of Superintendent in proceedings; brokers; issuance, revocation and renewal of required license; violations. [Repealed].

Repealed.

(April 9, 1997, D.C. Law 11-227, § 16, 44 DCR 140.)

Prior Codifications. — 1981 Ed., §§ 35-425 to 35-428.

Legislative history of Law 11-227. — Law 11-227, the “Insurance Agents and Brokers Licensing Revision Act of 1996,” was introduced in Council and assigned Bill No. 11-, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 1, 1996, and November 7, 1996, respectively. Signed by the Mayor on December 4, 1996, it was as-

signed Act No. 11-455 and transmitted to both Houses of Congress for its review. D.C. Law 11-227 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4301.

Editor’s notes. — D.C. Law 11-268, § 10(i) (44 DCR 1730), effective May 21, 1997, amends the repealed sections subsequent to repeal.

§ 31-4329. Disposition of premiums paid to agents.

An insurance agent, solicitor, or broker who acts in negotiating or renewing or continuing a contract of insurance for a company lawfully doing business in the District, and who receives any money or substitute for money as a premium for such a contract from the insured, whether he shall be entitled to an interest in same or otherwise, shall be deemed to hold such premium in trust for the company making the contract. If he fails to pay the same over to the company after written demand made upon him therefor, such failure shall be prima facie evidence that he has used or applied the said premium for a purpose other than paying the same over to the company, and upon conviction thereof he shall be deemed guilty of theft and punished accordingly.

(June 19, 1934, 48 Stat. 1142, ch. 672, ch. II, § 30; Aug. 2, 1983, D.C. Law 5-24, § 15, 30 DCR 3341.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-429. 1973 Ed., § 35-429.

Legislative history of Law 5-24. — Law 5-24, the “Technical and Clarifying Amendments Act of 1986,” was introduced in Council

and assigned Bill No. 5-169, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May 10, 1983, and May 24, 1983, respectively. Signed by the Mayor on June 9, 1983, it was assigned Act No. 5-41 and transmitted to both Houses of Congress for its review.

§ 31-4330. Contractual rights of minors.

Any minor of the age of 15 years or more may, notwithstanding such minority, contract for life, health, and accident insurance on his own life for his or her own benefit or for the benefit of his father, mother, spouse, child, brother, sister, or for the benefit of any person who has the care or custody of said minor or with whom said minor makes his or her home, and may exercise all such contractual rights with respect to any such contract of insurance as might be exercised by a person of full legal age and may at any time surrender his or her interest in any such insurance or give a valid discharge for any benefit accruing or money payable thereunder.

(June 19, 1934, 48 Stat. 1142, ch. 672, ch. II, § 31; Sept. 12, 2008, D.C. Law 17-231, § 28(b), 55 DCR 6758.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-430. 1973 Ed., § 35-430.

Effect of amendments. — D.C. Law 17-231 substituted “spouse” for “husband, wife”.

Legislative history of Law 17-231. — For Law 17-231, see notes following § 31-3301.01.

§ 31-4331. Assessment companies prohibited.

Any company which makes insurance or reinsurance the performance of which is not guaranteed by the reserves required by this subdivision, but is contingent upon the payment of assessments or calls made upon its members, shall not be formed, admitted, or licensed in the District.

(June 19, 1934, 48 Stat. 1142, ch. 672, ch. II, § 32; May 4, 1950, 64 Stat. 104, ch. 157, § 3.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-431. 1973 Ed., § 35-431.

§ 31-4332. Appeals from Commissioner to Mayor.

Any appeals to the Mayor from rulings of the Commissioner shall be perfected and filed with the Mayor within 20 days exclusive of Sundays and legal holidays from the date such rulings are communicated to the party at interest.

(June 19, 1934, 48 Stat. 1142, ch. 672, ch. II, § 33; May 21, 1997, D.C. Law 11-268, § 10(i), 44 DCR 1730.)

Cross references. — Examiner orders following mayor’s consideration of findings, appeals, see § 31-1404.

Managing general agent license suspension or revocation, appeal from mayor, see § 31-1506.

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-432. 1973 Ed., § 35-432.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4301.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4301.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of

Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office

of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CHAPTER 44. DOMESTIC LIFE COMPANIES.

Sec.		Sec.	
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§ 31-4401. Formation — Required contents of articles of incorporation.

Any 7 or more persons who desire to become incorporated as an insurance company shall make, sign, and acknowledge articles of incorporation before an officer authorized to take acknowledgment of deeds, in which shall be stated:

(1) The proposed corporate name, which shall not be identical with nor so nearly resemble the name of an existing corporation organized under the laws of the District, or authorized to transact business therein, as to mislead the

public or cause confusion and, in case of a mutual company, shall contain the word "mutual";

(2) The term of its existence, which may be perpetual;

(3) The place where its principal office shall be located, which shall be the District of Columbia;

(4) The purpose of the company, which shall be restricted to the business of insurance appertaining to persons;

(5) The mode and manner in which the corporate power shall be exercised; the number, terms of office, and manner of electing directors, who shall be stockholders, or, in the case of a mutual company, shall be members or policyholders of the corporation;

(6) The provisions for meeting and votes of stockholders and policyholders. A stock company in which the policyholders do not vote shall provide for cumulative voting in its articles of incorporation. A stock company in which policyholders vote shall provide that each stockholder shall have 1 vote, in person or by proxy, for each share of stock owned. A company without capital stock shall provide that every policyholder shall be a member and entitled to 1 or more votes, in person, or by proxy, based on the insurance in force, the number of policies held or the amount of premiums paid as may be provided in the bylaws, and a stock company may provide for votes by policyholders, but in such case each policyholder shall have the same voting power as every other policyholder;

(7) The amount of its capital stock, if any, the number of shares, and the par value of each share;

(8) The number of directors who shall manage the company for the 1st year and their names; and

(9) Such other particulars as may be necessary to manifest and explain the objects and purposes of the company.

(June 19, 1934, 48 Stat. 1143, ch. 672, ch. III, § 1.)

Cross references. — Health and accident companies, see § 31-5202.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prohibition against assessment companies, see § 31-4331.

Quo warranto proceedings to question right

to corporate rights and franchises, see § 16-3501 et seq.

Section references. — This section is referred to in § 31-733.

Prior Codifications. — 1981 Ed., § 35-601. 1973 Ed., § 35-501.

CASE NOTES

Workers' compensation.

Inasmuch as it would be inequitable to visit consequences of father's conflict of interest upon his disabled son, workman would not be found to be estopped from asserting tolling provisions of workmen's compensation limitation statute merely because his father, as president and sole shareholder of corporate employer, had conflict of interest in the case. Longshoremen's and Harbor Workers' Compensation Act, § 35 as amended 33 U.S.C. § 935; D.C. Code § 35-501 et seq.; Code -Va.1950,

§§ 65.1-1 to 65.1-152. Director, Office of Workers' Compensation Programs, etc. v. National Van Lines, Inc., 613 F.2d 972, 1979 U.S. App. LEXIS 10555 (C.A.D.C. 1979), writ of certiorari denied by 448 U.S. 907, 100 S. Ct. 3049, 65 L. Ed. 2d 1136, 1980 U.S. LEXIS 2467, 104 L.R.R.M. (BNA) 2688 (1980).

Where, pursuant to Longshoremen's and Harbor Workers' Compensation Act, employer's insurance carrier pays workmen's compensation benefits to injured employee under award, it is subrogated to all employer's rights

and thereby becomes assignee of employee's claim against third party, unless employee himself brought action against alleged wrongdoer within six months after award. Longshoremen's and Harbor Workers' Compensation Act, § 33(b, h), 33 U.S.C. § 933(b, h). *Travelers Ins. Co. v. District of Columbia*, 382 A.2d 269, 1978 D.C. App. LEXIS 408 (1978).

Employer who pays workmen's compensation without award is not thereby barred by Longshoremen's and Harbor Workers' Compensation Act from pursuing whatever nonstatutory rights he may have against third-party wrongdoers. Longshoremen's and Harbor Workers' Compensation Act, §§ 1-50, 33 U.S.C. §§ 901-950; D.C. Code § 35-502. *Travelers Ins. Co. v. District of Columbia*, 382 A.2d 269, 1978 D.C. App. LEXIS 408 (1978).

Where employer's workmen's compensation insurer paid workmen's compensation to injured employee without formal award, where employee brought action against District of Columbia as third-party wrongdoer, and where employer's workmen's compensation insurer failed to affirmatively assert any lien claim

prior to payment of settlement proceeds by District to employee even though insurer was aware of employee's suit, insurer's complaint against District for District's failure to protect insurer's alleged equitable lien on proceeds paid by District to employee in settlement of negligence action failed to state cause of action. *Travelers Ins. Co. v. District of Columbia*, 382 A.2d 269, 1978 D.C. App. LEXIS 408 (1978).

Where workmen's compensation insurer failed to timely assert its lien claim on proceeds paid by third-party wrongdoer to employee in settlement of employee's negligence action, lien did not arise on settlement proceeds prior to their payment to employee and third-party wrongdoer was justified in paying proceeds to injured employee rather than to workmen's compensation insurer; therefore, payment did not constitute "independent wrong" against insurer from which insurer's action for damages would lie. Longshoremen's and Harbor Workers' Compensation Act, §§ 1-50, 33 U.S.C. §§ 901-950; D.C. Code § 35-502. *Travelers Ins. Co. v. District of Columbia*, 382 A.2d 269, 1978 D.C. App. LEXIS 408 (1978).

§ 31-4402. Formation — Filing, notice and bond requirements.

The incorporators shall file such articles with the Commissioner and shall publish in a newspaper of general circulation in the District notice of the filing of such articles and of the intention to form such company. Copy of such notice verified by the oath of the publisher of the newspaper, or his agent, copies of proposed bylaws and forms of subscription for capital stock and of proposed applications for membership and for insurance and of all proposed forms of insurance policies, literature, and advertisements shall be filed with the Commissioner. The incorporators shall also file with the Commissioner a bond payable to the Commissioner and his successors, as trustee, in the sum of \$10,000 with approved corporate sureties, and conditioned upon the faithful accounting to the proposed company, on completion of its organization and the receipt of its certificate of authority from the Commissioner, or the stockholders, members, applicants for policies, and creditors, or the trustee, receiver, or assignee of the proposed company, duly appointed in any proceedings in any court or department of competent jurisdiction in the District, in accordance with their respective rights in case the organization of the proposed company shall not be completed and a certificate of authority shall not be procured from the Commissioner.

(June 19, 1934, 48 Stat. 1144, ch. 672, ch. III, § 2; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-602. 1973 Ed., § 35-502.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill

No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Depart-

ment would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

§ 31-4403. Formation — Corporate powers during completion of organization; issuance of certificate of authority.

(a) The Commissioner shall examine the proposed articles and other papers so filed with him and, if he finds the same in accordance with law, he shall so certify and return the same to the Commissioner, who shall cause the articles and the certificate of the Corporation Counsel to be recorded in the records of the Commissioner and issue to the incorporators 2 certified copies thereof, one of which shall be recorded in the Office of the Recorder of Deeds for the District of Columbia, and thereupon such incorporators and their associates shall become and be a body corporate with power to sue and be sued, contract and be contracted with, adopt a seal, and do such other acts, subject to the provisions of this subdivision, as shall be needful to accomplish the purposes of its organization. If the Commissioner shall approve the sureties on the bond so filed, or on any like bond substituted therefor, he shall issue to the corporation a permit, as a "company in course of organization," authorizing it to complete its organization. Said company in course of organization shall have authority under such permit to solicit subscriptions and payments for capital stock, if a stock company, and applications and advance premiums for insurance, and to exercise such powers, subject to the limitations in this subdivision prescribed, as may be necessary and proper in completing its organization and qualifying itself for a certificate of authority from the Commissioner to transact the business of insurance appertaining to persons. But such company shall not issue policies or enter into contracts of insurance until it shall have received the certificate of the Commissioner authorizing it so to do.

(b) Upon completion of organization in accordance with this subdivision the Commissioner shall issue to such company, in course of organization, a certificate of authority as an insurance company.

(June 19, 1934, 48 Stat. 1144, ch. 672, ch. III, § 3; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730; Mar. 8, 2007, D.C. Law 16-232, § 205(b)(1), 54 DCR 368.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-603. 1973 Ed., § 35-503.

Effect of amendments. — D.C. Law 16-232, in subsec. (a), substituted “The Commissioner shall examine the proposed articles and other papers so filed with him” for “The Commissioner shall submit the proposed articles and other papers so filed with him to the Corporation Counsel of the District, who shall examine the same”.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4404. Formation — Authority to solicit stock subscriptions or insurance applications.

No person shall solicit subscriptions for the capital stock of or applications for insurance in any such company in course of organization unless he has been duly authorized by the company and a certificate of his authority, duly signed by a principal officer of the company, has been filed with and approved by the Commissioner.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 4; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-604. 1973 Ed., § 35-504.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4402.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4405. Formation — Disposition of sums paid upon stock subscriptions.

Every subscription to the capital stock of a stock company shall contain the stipulation that no sum shall be used for commission, promotion, or organization expenses in excess of a percentage of the amount paid upon the stock subscriptions, to be named in such stipulation and proved by the Commissioner, and the remainder of sums so paid to the company shall be invested in securities in which a life insurance company is authorized to invest, or deposited in a bank or trust company in the District until the company has duly procured a certificate of authority from the Commissioner.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 5; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-605. 1973 Ed., § 35-505.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4406. Formation — Examination of company; revocation and reinstatement of company's permit or agent's authority.

The Commissioner shall personally, or through his Deputy and assistants, examine into the affairs of any such company in course of organization and inspect its books and papers, and may summon and examine under oath any officer or agent or any person who is or has been connected with or who has knowledge of the affairs of such company, and if he finds the company is violating the law, or if the company shall not be qualified for a certificate of authority within 2 years from date of its permit, he shall revoke its permit; and if he finds an agent of such company has violated the law, he shall revoke his authority, and he may for such agent's violation revoke the company's permit. Any revocation shall be after 20 days' notice. The Commissioner may, on proper showing, reinstate any company's permit or agent's authority which he has revoked.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 6; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-606. 1973 Ed., § 35-506.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4407. Formation — Time limitation for issuance of policies.

If any domestic life insurance company, in course or organization, shall not commence to issue policies within 2 years from the date of filing its articles of incorporation in the office of the Commissioner, its powers shall thereby cease, and the court, upon petition of the Commissioner or of any person interested, may fix by decree the time in which the Commissioner may settle and close its affairs; provided, however, that the Commissioner may extend the time for any such company to commence the issuance of policies for a period not exceeding 2 years if the said company shall show good cause in writing why the same should be done.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 7; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-607. 1973 Ed., § 35-507.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance

abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4408. Minimum capital and surplus requirements.

(a) A domestic capital-stock company organized under this subdivision shall have a paid-up capital stock of not less than \$1,000,000. Each domestic capital-stock company organized under this subdivision, in addition to the paid-up capital stock, shall have a surplus paid-up equal to at least 50% of such capital stock. Each domestic mutual company organized or doing business under this subdivision shall at all times have a surplus as defined by this subdivision of not less than \$1,500,000.

(b) No company shall be exempt from the provisions of this section by reason of its having been incorporated in the District or elsewhere prior to the effective date of this subsection or subsequent amendment, except that in the case of companies authorized in the District of Columbia on August 31, 1964, and continuously authorized thereafter without any increase or broadening of authority, the minimum capital required of a stock company, or the minimum surplus required of a mutual company, shall not be increased by this section.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 8; May 4, 1950, 64 Stat. 104, ch. 157, § 4; Aug. 31, 1964, 78 Stat. 764, Pub. L. 88-556, § 1; Aug. 14, 1973, 87 Stat. 303, Pub. L. 93-89, title II, § 201(1), (2).)

Cross references. — Independent certified public accountant report, minimum capital and surplus requirement, see § 31

Prior Codifications. — 1981 Ed., § 35-608. 1973 Ed., § 35-508.

References in text. — “The effective date of this subsection,” referred to in subsection (b) of this section, is prescribed by § 5 of the Act of August 31, 1964, 78 Stat. 764, Pub. L. 88-557.

§ 31-4409. Amendment of articles of incorporation.

Any company may amend its articles of incorporation upon publishing notice of such intention, authorized by a majority of its directors, once a week for 3 consecutive weeks in a newspaper of general circulation in the District, and with the written consent of stockholders representing at least two thirds of the capital stock entitled to vote, or two thirds of its members present in person or by proxy at a meeting called for that purpose if it does not have capital stock, and by observing such other and further requirements in that behalf as may be prescribed in its articles of incorporation. Such amendment shall be signed and acknowledged by the president and secretary or like officers of the company, and, with a copy of the proceedings of the stockholders or members, if any, and of the directors, shall be filed with the Commissioner and by him submitted to the Corporation Counsel, and if he finds the amendment and proceedings in conformity with the law, he shall so certify to the Commissioner. The amendment shall not take effect until the Commissioner shall deliver to the company his certified copy of the amendment and of the certificate of the Corporation Counsel.

(June 19, 1934, 48 Stat. 1145, ch. 672, ch. III, § 9; Aug. 31, 1964, 78 Stat. 765, Pub. L. 88-556, § 3; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-609. 1973 Ed., § 35-509.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4410. Increase of capital stock.

(a) If a company amends its articles of incorporation by providing for an increase of its capital stock, such increase shall be subscribed and fully paid up within 1 year of the date of such amendment, unless the Commissioner shall certify his consent to an extension of such time. Failure to have such increase of capital stock paid up within the time provided may be considered grounds for ousting the company from its powers under any such amendment to such articles of incorporation by a court of competent jurisdiction in a proceeding by the Commissioner, the Corporation Counsel representing him, against the company for such judgment.

(b) Subsection (a) of this section shall not be applicable to an amendment of the articles of incorporation providing for an increase of capital stock wherein said amendment provides that said increase will be reserved for issuance for: (1) the acquisition of the ownership or control of another insurance company as an affiliate or subsidiary subject to the limitations of § 31-4435(a)(10)(B) [repealed]; provided, however, that no such acquisition shall be consummated until it has been approved or ratified by stockholders representing at least a majority of the capital stock entitled to votes; (2) the granting of options to officers or employees of the company to purchase authorized but unissued shares of stock of the company, for such consideration and upon such terms and conditions as may be fixed by the board of directors; provided, however, that: (A) at no time shall the number of shares reserved for this purpose exceed, in the aggregate, 5% of the total authorized shares of stock of the company; (B) no more than 10% of the total number of shares authorized to be optioned may be made available to any individual under any and all options issued to him by the company; (C) no option shall be promised or granted: (i) to any individual employed by an insurance company authorized to do business in the District of Columbia (other than the company promising or granting the option or a subsidiary of the company promising or granting the option) while that individual is so employed; or (ii) to any individual within 2 years following the termination of his employment with such an insurance company; (D) the option price of shares subject to any such option shall not be less than 95% of the fair market value of such shares at the time the option is granted and shall be not less than the par value of such shares; (E) any such option shall not be transferable except by will or the laws of descent and distribution; and (F) any such option shall not be exercisable after the expiration of 10 years from the time the option is granted; or (3) the paying of stock dividends; provided, that at no time shall the number of shares of reserved unissued stock exceed the number of shares of issued and outstanding shares of stock of said company.

(June 19, 1934, 48 Stat. 1146, ch. 672, ch. III, § 10; Aug. 31, 1964, 78 Stat. 765,

Pub. L. 88-556, § 4; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 24(a), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-610. 1973 Ed., § 35-510.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Commit-

tee of the Whole. The Bill was adopted on first and second readings on November 4, 1997 and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4411. Decrease of capital stock.

A company may, with the approval of the Commissioner, amend its articles of incorporation by providing for a decrease of its capital stock and a corresponding increase in surplus to an amount not less than the minimum capital stock and surplus required by this subdivision. The Commissioner shall not approve or issue his certified copy of such amendment if he be of the opinion that the interests of policyholders or creditors may be prejudiced thereby. No distribution of the assets of the company shall be made to stockholders upon any such decrease of capital stock which shall reduce the surplus and capital stock to less than the minimum capital stock and surplus required as aforesaid. Upon any such amendment so decreasing the capital stock such company may require each stockholder to return his certificate of stock and accept a new certificate for such proportion of the amount of its original capital stock as the reduced capital stock shall bear to the original capital stock.

(June 19, 1934, 48 Stat. 1146, ch. 672, ch. III, § 11; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-611. 1973 Ed., § 35-511.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4412. Liability of stockholders; rights of fiduciary stockholders and persons pledging stock.

(a) All the stockholders of every company incorporated under this chapter shall be severally and individually liable to the policyholders and creditors of the company in which they are stockholders for the unpaid amount due upon the shares of capital stock held by them, respectively, for all debts and contracts made by such company until the whole amount of capital stock fixed and limited by such company shall have been paid in.

(b) No person holding capital stock in such company as executor, administrator, guardian, committee, or trustee shall be personally subject to any liability as stockholder of such company, but the estate and funds in the hands

of such executor, administrator, guardian, committee, or trustee shall be liable in like manner and to the same extent as the testator or intestate or the ward or person interested in such trust would have been if he had been living and competent to act and hold the stock in his own name.

(c) Every such executor, administrator, guardian, committee, or trustee shall represent the capital stock in his hands at all meetings of the company, and may vote accordingly as a stockholder.

(d) No person holding capital stock in such company as collateral security shall be personally subject to any liability as stockholder of such company, but the person pledging such capital stock shall be considered as holding the same, and shall be liable as a stockholder accordingly; and every person who shall pledge his capital stock as collateral security may, nevertheless, represent the same at all meetings and vote as a stockholder.

(June 19, 1934, 48 Stat. 1146, ch. 672, ch. III, § 12.)

Prior Codifications. — 1981 Ed., § 35-612. 1973 Ed., § 35-512.

§ 31-4413. Payments for capital stock.

No company incorporated under this chapter shall be authorized to transact any business until the authorized capital stock shall have been actually paid in, either in cash or in investments authorized by this subdivision at market value; and it shall be lawful for the directors to call in and demand from the stockholders the residue of their subscriptions in money or property at such times and in such instalments as the directors shall deem proper, under the penalty of forfeiting the shares of capital stock subscribed for and all previous payments made thereon, if payment shall not be made by the stockholder within 60 days after a personal demand or a notice requiring such payment shall have been published once a week for 3 consecutive weeks in a daily newspaper in the District.

(June 19, 1934, 48 Stat. 1147, ch. 672, ch. III, § 13.)

Prior Codifications. — 1981 Ed., § 35-613. 1973 Ed., § 35-513.

§ 31-4414. Capital stock transfers.

(a) The capital stock of such company shall be deemed personal estate and shall be transferable in such manner as shall be prescribed by the bylaws of the company; but no shares shall be transferable until all previous calls thereon shall have been fully paid in or the shares shall have been declared forfeited for nonpayment.

(b) A person in whose name shares of capital stock stand on the books of a company shall be deemed the owner thereof as regards the company, but if any such person shall in good faith sell or otherwise dispose of any of his shares of capital stock to another and deliver to him the certificates for such shares, with written authority for the transfer of the same on the books, the title of the former shall vest in the latter so far as may be necessary to effect the purpose

of the sale or other disposition, not only as between the parties themselves but also as against the creditors of and subsequent purchasers from the former.

(June 19, 1934, 48 Stat. 1147, ch. 672, ch. III, § 14.)

Prior Codifications. — 1981 Ed., § 35-614. 1973 Ed., § 35-514.

§ 31-4415. Capital stock records.

(a) It shall be the duty of the directors of every domestic stock company to cause a record to be kept by the treasurer or secretary of the company or by the stock transfer agent of the company containing the names of all persons, alphabetically arranged, who are or shall within 6 years have been stockholders of such company, and showing their place of residence, the number of shares of capital stock held by them, respectively, the time when they became owners of such shares, and the amount of capital stock actually paid in.

(b) Such record shall, during the usual business hours of the day, on every business day, be open for inspection by policyholders, stockholders, creditors of the company, and the personal representatives of such policyholders, stockholders, and creditors at the office or principal place of business of such company in the place where its business operations shall be located in the District of Columbia, or at the office of the stock transfer agent located in the District of Columbia, and any policyholder, stockholder, creditor, or representative shall have a right to make extracts from such record.

(c) Such record shall be presumptive evidence of the facts therein stated in favor of the plaintiff in any suit or proceeding against such company or against any 1 or more stockholders.

(d) Every officer, stock transfer agent, or any other agent of any company who shall neglect to make any proper entry in such record, or shall refuse or neglect to exhibit the same, or allow the same to be inspected and extracts to be taken therefrom, as herein provided, shall be deemed guilty of a misdemeanor and the company shall pay to the party injured a penalty of \$50 for any such neglect or refusal, and all damages resulting therefrom.

(e) Every company that shall neglect to have such record kept open for inspection, as herein provided, shall forfeit to the District the sum of \$50 for every day it shall so neglect, to be sued for and recovered by the Commissioner, the Corporation Counsel representing him, in the Superior Court of the District of Columbia.

(June 19, 1934, 48 Stat. 1147, ch. 672, ch. III, § 15; June 25, 1936, 49 Stat. 1921, ch. 804; June 25, 1948, 62 Stat. 991, ch. 646, § 32(b); May 24, 1949, 63 Stat. 107, ch. 139, § 127; Aug. 20, 1964, 78 Stat. 556, Pub. L. 88-458, § 1; July 29, 1970, 84 Stat. 572, Pub. L. 91-358, title I, § 155(c)(37)(C); May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-615. 1973 Ed., § 35-515.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4416. Mutual companies — Corporations, boards, or associations as agents or members thereof.

Public or private corporations, boards, or associations of the District or elsewhere may make applications, enter into agreements for, hold policies in, and become members of mutual companies. Any officer, stockholder, trustee, or legal representative of any such corporation, board, association, or of an estate may be recognized as acting for or on its behalf, but shall not be personally liable by reason of acting in such representative capacity.

(June 19, 1934, 48 Stat. 1148, ch. 672, ch. III, § 16.)

Prior Codifications. — 1981 Ed., § 35-616. 1973 Ed., § 35-516.

§ 31-4417. Formation — Requirements before doing business.

No domestic mutual company shall transact any business until at least 200 persons shall have subscribed in the aggregate for at least \$200,000 of insurance and shall have paid in full 1 annual premium in money upon the insurance so subscribed.

(June 19, 1934, 48 Stat. 1148, ch. 672, ch. III, § 17.)

Cross references. — Prohibition against assessment companies, see § 31-4331.

Prior Codifications. — 1981 Ed., § 35-617. 1973 Ed., § 35-517.

§ 31-4418. Reincorporation of existing corporations.

(a) Any domestic insurance corporation existing or doing business on June 19, 1934, may, by a vote of a majority of its directors or trustees, accept the provisions of this subdivision and amend its charter to conform with the same upon obtaining the consent of the Commissioner thereto in writing, and filing such consent in the Office of the Recorder of Deeds for the District; and thereafter it shall be deemed to have been incorporated under this chapter, and every such corporation in reincorporating under this provision may for that purpose so adopt in whole or in part a new charter, in conformity herewith, and include therein any and all provisions of its existing charter, and any or all changes from its existing charter, to cover and enjoy any or all the privileges and provisions of existing laws which might be so included and enjoyed if it were originally incorporated hereunder, and it shall, upon such adoption of and after obtaining the consent, as in this section before provided, to such charter and filing the same with the Commissioner and the record thereof with the Recorder of Deeds of the District, perpetually enjoy the same as and be such corporation, which is declared to be a continuation of such corporation which existed prior to such reincorporation; and the offices therein which shall be continued shall be filled by the respective incumbents for the period and the

same general proceedings shall be taken upon the presentation of such amended charter or certificate adopted in relation to such amendment, to the Commissioner, as are required by this chapter to be taken with respect to an original charter or certificate, except that no examination of the condition and affairs of such corporation shall be required unless so ordered by the Commissioner, and if the amended charter or certificate be approved by the Commissioner and his certificate of authority to do business thereunder is granted, the corporation shall thereafter be deemed to possess the same powers and be subject to the same liabilities as if such charter or certificate so amended had been its original charter or certificate of incorporation, but without prejudice to pending action or proceeding or any rights previously accrued.

(b) Upon the reincorporation or upon the amendment of the charter of any corporation having a capital stock in accordance with the provisions of this section it may by a vote of the majority of its directors confer upon its policyholders as may have a prescribed amount of insurance upon their lives the right to vote for all or any less number of the directors in such manner not inconsistent with any provision of this subdivision.

(June 19, 1934, 48 Stat. 1148, ch. 672, ch. III, § 18; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-618. 1973 Ed., § 35-518.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4419. Conversion of stock companies into mutual life companies.

Any domestic stock company organized or licensed to do business, whether incorporated under this subdivision, or any previous existing law, or act of Congress, may become a mutual company, and to that end may carry out a plan for the acquisition of shares of its capital stock; provided, however, that such plan:

(1) Shall have been adopted by a vote of a majority of the directors of such company;

(2) Shall have been approved by a vote of stockholders representing a majority of the capital stock at a meeting of stockholders called for the purpose;

(3) Shall have been approved by a majority vote of the policyholders voting at a meeting, called for the purpose, of policyholders each insured for at least \$1,000 and whose insurance shall then be in force and shall have been in force for at least 1 year prior to such meeting; notice of such meeting shall be given by mailing such notice from the home office of such corporation at least 30 days prior to such meeting, in a sealed envelope, postage prepaid, addressed to such policyholders at their last known post-office addresses, and such meeting shall be otherwise provided for and conducted in such manner as shall be provided in such plan; provided, however, that policyholders may vote in person, by proxy, or by mail; that all votes shall be cast by ballot and the

Commissioner shall supervise and direct the methods and procedure of said meeting and appoint an adequate number of inspectors to conduct the voting at said meeting who shall have power to determine all questions concerning the verification of the ballots, the ascertainment of the validity thereof, the qualifications of the voters, and the canvass of the vote, and who shall certify to the Commissioner and to the company the result thereof, and with respect thereto shall act under such rules and regulations as shall be prescribed by the Council of the District of Columbia; that all necessary expenses incurred by the Commissioner shall be paid by the company as certified to by him; and

(4) Shall have been submitted to the Commissioner and shall have been approved by him in writing; provided, that every payment for the acquisition of any shares of the capital stock of such company, the purchase price of which is not fixed by such plan, shall be subject to the approval of the Commissioner; provided further, that neither such plan, nor any such payment, shall be approved by the Commissioner unless at the time of such approvals, respectively, the company, after deducting the aggregate sum appropriated by such plan for the acquisition of any part or all of its capital stock, and in the case of any payment not fixed by such plan and subject to separate approval as aforesaid after the approval of such plan, after deducting also the amount of such payment, shall be possessed of assets not less than the entire liabilities of the company, including the net values of its outstanding contracts computed according to the standard adopted by the company under § 31-4701, and also all funds, contingent reserves, and surplus save so much of the latter as shall have been appropriated or paid under such plan.

(June 19, 1934, 48 Stat. 1149, ch. 672, ch. III, § 19; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-619. 1973 Ed., § 35-519.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 35-602.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 402(274) of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of

the functions of the Board of Commissioners under this section to the District of Columbia Council, subject to the right of the Commissioner as provided in § 406 of the Plan. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-4420. Applicability of provisions to existing corporations.

Every company incorporated under the provisions of the laws of the District, or act of Congress, prior to June 19, 1934, is hereby brought under all the provisions of this subdivision, except that its capital may continue in the

amount named in its charter during the existing term thereof, unless it extends its business to other kinds of insurance, and it shall be entitled to all privileges granted by such charter not authorized by this law.

(June 19, 1934, 48 Stat. 1149, ch. 672, ch. III, § 20.)

Prior Codifications. — 1981 Ed., § 35-620. 1973 Ed., § 35-520.

§ 31-4421. Directors — Annual election; qualifications; limitation on proxies.

The stock, property, and business of every company organized under this subdivision shall be managed by the directors who shall, except for the 1st year, be annually elected, at such time and place as shall be determined by the bylaws of the company. All proxies used in the election of directors of such companies shall be valid for a period not exceeding 1 year from the election for which they were signed and in which they were authorized to be voted.

(June 19, 1934, 48 Stat. 1149, ch. 672, ch. III, § 21; Mar. 8, 2007, D.C. Law 16-232, § 205(b)(2), 54 DCR 368.)

Cross references. — Mutual insurance holding company, membership interest, see § 31-735.

Quo warranto proceedings to question right to corporate office, see § 16-3501 et seq.

Prior Codifications. — 1981 Ed., § 35-621. 1973 Ed., § 35-521.

Effect of amendments. — D.C. Law 16-232

deleted the second sentence, which had read: "Every director of such a stock company shall be a stockholder thereof, and every director of such a mutual company shall be a policyholder thereof."

Legislative history of Law 16-232. — For Law 16-232, see notes following § 31-231.

§ 31-4422. Directors — Power to make bylaws.

The directors of companies organized under this subdivision shall have power to make such bylaws as they deem proper for the management of the business affairs of such company, not inconsistent with the laws of the District and the Constitution of the United States, and prescribing the duties of officers, employees, and servants that may be employed, for the appointment or election of all officers, and for carrying on all kinds of business within the objects and purposes of such company.

(June 19, 1934, 48 Stat. 1150, ch. 672, ch. III, § 22.)

Prior Codifications. — 1981 Ed., § 35-622. 1973 Ed., § 35-522.

§ 31-4423. Directors — General election procedure.

(a) Notice of the time and place of holding election of directors of a company organized under this subdivision shall be sent to those entitled to vote, and the election shall be made by such of the stockholders and/or policyholders as shall attend for that purpose, either in person or by proxy. All elections shall be by ballot, and the persons receiving the greatest number of votes shall be directors. When any vacancy shall happen among the directors it shall be filled

for the remainder of the year in such manner as shall be prescribed by the bylaws of the company.

(b) In case it shall happen at any time that an election of directors shall not be made on the day designated by the bylaws of said company when it ought to have been made, the company shall not for that reason be dissolved, but it shall be lawful on any other day to hold an election for directors in such manner as may be provided in the bylaws, and all acts of directors shall be valid and binding as against said company until their successors shall be elected.

(June 19, 1934, 48 Stat. 1150, ch. 672, ch. III, § 23.)

Prior Codifications. — 1981 Ed., § 35-623. 1973 Ed., § 35-523.

§ 31-4424. Directors — Cumulative voting in stock company election.

In an election for directors of any stock company in which the policyholders do not vote, each stockholder having a right to vote may cast the whole number of his votes for 1 candidate, or distribute them upon 2 or more candidates, as he may prefer, that is to say: If the stockholder having a right to vote owns 1 share of stock, or has 1 vote, or is entitled to 1 vote for each of 7 directors by virtue thereof, he may give 1 vote to each of said 7 directors, or 7 votes for any 1 thereof, or a less number of votes for any less number of directors, whatever may be the actual number to be elected, and in this manner may distribute or cumulate his votes as he may see fit.

(June 19, 1934, 48 Stat. 1150, ch. 672, ch. III, § 24.)

Prior Codifications. — 1981 Ed., § 35-624. 1973 Ed., § 35-524.

§ 31-4425. Voting powers under group policies.

In every group policy issued by a domestic life company the employer shall be deemed to be the policyholder for all purposes, within the meaning of this chapter, and, if entitled to vote at meetings of the company, shall be entitled to 1 vote thereat.

(June 19, 1934, 48 Stat. 1150, ch. 672, ch. III, § 25.)

Prior Codifications. — 1981 Ed., § 35-625. 1973 Ed., § 35-525.

§ 31-4426. Liability of directors.

The directors of any company organized under the laws of the District shall be personally liable when they have participated in or assented to any act which shall cause injury to policyholders, creditors, or stockholders resulting from: (1) ultra vires acts; (2) illegal corporate acts done with their connivance, knowledge, or consent; (3) issuing unpaid or part-paid stock and marking or representing it as paid up in full; (4) dividend payments declared whether negligently or purposely impairing the capital stock and minimum surplus; (5)

mismanagement; (6) loaning corporate funds to stockholders or discounting their notes out of corporate moneys; (7) making false notices or reports that deceive the public; or, (8) transferring property to officers or stockholders to defraud policyholders or creditors. If any of the directors shall object to declaring a dividend or the payment of the same, and shall, at any time before the time fixed for the payment thereof, file a certificate of their objections in writing with the secretary of the company and with the Commissioner, they shall be exempt from the liability prescribed in this section for dividends declared or paid impairing the capital stock and minimum surplus.

(June 19, 1934, 48 Stat. 1150, ch. 672, ch. III, § 26; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 24(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-626. 1973 Ed., § 35-526.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4410.

CASE NOTES

Ultra vires acts.

Claim that president and director of corporation is personally liable for participating in “ultra vires” act to detriment of corporation and for being pecuniarily interested in corporation

transactions in violation of statute should be maintainable as part of a derivative action. D.C. Code §§ 35-526, 35-530. *Johnson v. American General Ins. Co.*, 296 F. Supp. 802, 1969 U.S. Dist. LEXIS 10465 (D.D.C.1969).

§ 31-4427. Salaries to be authorized by directors.

No domestic company shall pay any salary, compensation, or emolument to any officer, trustee, or director thereof, amounting in any 1 year to more than \$5,000, unless such payment shall be authorized by the board of directors of the company.

(June 19, 1934, 48 Stat. 1151, ch. 672, ch. III, § 27.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-627. 1973 Ed., § 35-527.

§ 31-4428. Limitation of payments to stockholders and policyholders.

No domestic company shall make any payments in form of dividends or otherwise to its stockholders for or on account of any interest in or relation to the company as stockholders unless it possesses assets in the amount of such payment in excess of its liabilities, including its capital stock, and the surplus required by this subdivision; and no domestic company shall make any payments to its policyholders for or on account of any interest in or relation to the company as members or policyholders except for matured claims or other policy obligations and in the purchase of surrender values unless it possesses

assets in the amount of such payments in excess of its liabilities, and the capital stock and surplus required by this subdivision.

(June 19, 1934, 48 Stat. 1151, ch. 672, ch. III, § 28.)

Prior Codifications. — 1981 Ed., § 35-628. 1973 Ed., § 35-528.

§ 31-4429. Election or appointment of officers; required security.

There shall be a president, a secretary, and a treasurer of the company, who shall be elected by the directors; and also such subordinate officers as may be elected or appointed, and who may be required to give security for the faithful performance of the duties of their office, as this subdivision and the company by its bylaws may require.

(June 19, 1934, 48 Stat. 1151, ch. 672, ch. III, § 29.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Quo warranto proceedings to question right to corporate office, see § 16-3501 et seq.

Prior Codifications. — 1981 Ed., § 35-629. 1973 Ed., § 35-529.

§ 31-4430. Officers and directors not to be pecuniarily interested in transactions.

No director or officer of any company doing business in the District shall receive any money or valuable thing for negotiating, procuring, recommending, or aiding in any purchase by or sale to such company of any property, or any loan from such company, nor be pecuniarily interested, either as principal, coprincipal, agent, or beneficiary, in any such purchase, sale, or loan, nor shall the financial obligation of any such director or officer be guaranteed by such company in any capacity; provided, that nothing herein contained shall prevent any such director or officer from receiving a fee for appraising property for said company or for serving on any committee that passes on the investments of said company; provided further, that nothing herein contained shall prevent a life insurance company from making a loan upon a policy held therein by a director or officer not in excess of the net value thereof or prevent any company in connection with the relocation of the place of employment of an officer, including any relocation in connection with the initial employment of such officer from: (1) making (or such officer from accepting therefrom) a mortgage loan to such officer on real property owned by such officer which is to serve as such officer's residence; or (2) acquiring (or such officer from selling thereto), at not more than the fair market value thereof, the residence of such officer. Any person violating any provision of this section shall be guilty of a misdemeanor.

(June 19, 1934, 48 Stat. 1151, ch. 672, ch. III, § 30; Apr. 16, 1982, D.C. Law 4-99, § 2, 29 DCR 967.)

Cross references. — Hospital and medical services corporation, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-630. 1973 Ed., § 35-530.

Legislative history of Law 4-99. — Law 4-99, the "Life Insurance Act Amendment of 1981," was introduced in Council and assigned

Bill No. 4-325, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on January 26, 1982, and February 9, 1982, respectively. Signed by the Mayor on February 22, 1982, it was assigned Act No. 4-157 and transmitted to both Houses of Congress for its review.

CASE NOTES

ANALYSIS

Construction and application.

Loans.

Pecuniary interests.

Construction and application.

District of Columbia statute providing that no director or officer of any insurance company doing business in the district shall receive any money or valuable thing for negotiating any loan from company or be pecuniarily interested in any such loan is regulatory and is intended to secure fiduciary relationship from being utilized in manner which might give rise to conflict of interest and is not intended to punish one who violates the statute, hence the rule of strict construction of criminal statute is to be relaxed. D.C. Code § 35-530. *Jordan v. Acacia Mut. Life Ins. Co.*, 409 F.2d 1141, 1969 U.S. App. LEXIS 8847 (C.A.D.C. 1969), writ of certiorari denied by 395 U.S. 959, 89 S. Ct. 2101, 23 L. Ed. 2d 746, 1969 U.S. LEXIS 1287 (1969).

Inasmuch as statute prohibiting director or officer of life insurer from obtaining loan from insurer provided that any person violating statute should be guilty of misdemeanor, statute must be treated as a penal statute. D.C. Code § 35-530. *Acacia Mut. Life Ins. Co. v. Jordan*, 283 F. Supp. 766, 1968 U.S. Dist. LEXIS 7850 (D.D.C.1968), reversed by 409 F.2d 1141, 133 U.S. App. D.C. 224, 1969 U.S. App. LEXIS 8847 (1969).

Loans.

Under District of Columbia statute providing that no director or officer of any insurance company doing business in the district shall receive any money or valuable thing for negotiating any loan from the company or be pecuniarily interested in any such loan, person who is interested as principal in loan from insurance company is barred from becoming a director even though his interest in the loan arose prior to his becoming a director. D.C. Code § 35-530. *Jordan v. Acacia Mut. Life Ins. Co.*, 409 F.2d 1141, 1969 U.S. App. LEXIS 8847 (C.A.D.C. 1969), writ of certiorari denied by 395 U.S. 959, 89 S. Ct. 2101, 23 L. Ed. 2d 746, 1969 U.S. LEXIS 1287 (1969).

Portion of section of District of Columbia Code to effect that no director or officer of any life insurer doing business in district shall receive any money or valuable thing for negotiating, procuring, recommending or aiding in any loan from such insurer was intended to bar director or officer from receiving any compensation, such as broker's commission, for procuring a loan to be made and to prevent director or officer from borrowing any money from insurer while he was director or officer. D.C. Code § 35-530. *Acacia Mut. Life Ins. Co. v. Jordan*, 283 F. Supp. 766, 1968 U.S. Dist. LEXIS 7850 (D.D.C.1968), reversed by 409 F.2d 1141, 133 U.S. App. D.C. 224, 1969 U.S. App. LEXIS 8847 (1969).

Person who had borrowed money from District of Columbia insurance company was eligible to become member of board of directors or officer of company while loan was outstanding. D.C. Code § 35-530. *Acacia Mut. Life Ins. Co. v. Jordan*, 283 F. Supp. 766, 1968 U.S. Dist. LEXIS 7850 (D.D.C.1968), reversed by 409 F.2d 1141, 133 U.S. App. D.C. 224, 1969 U.S. App. LEXIS 8847 (1969).

Section of District of Columbia Code banning director or officer of any insurer from being pecuniarily interested, either as principal, co-principal, agent or beneficiary in any purchase by, or sale to, insurer or any loan from insurer relates to transaction of lending money and does not apply to status of loan and is not effective during entire period when loan is in existence. D.C. Code § 35-530. *Acacia Mut. Life Ins. Co. v. Jordan*, 283 F. Supp. 766, 1968 U.S. Dist. LEXIS 7850 (D.D.C.1968), reversed by 409 F.2d 1141, 133 U.S. App. D.C. 224, 1969 U.S. App. LEXIS 8847 (1969).

Pecuniary interests.

Claim that president and director of corporation is personally liable for participating in "ultra vires" act to detriment of corporation and for being pecuniarily interested in corporation transactions in violation of statute should be maintainable as part of a derivative action. D.C. Code §§ 35-526, 35-530. *Johnson v. American General Ins. Co.*, 296 F. Supp. 802, 1969 U.S. Dist. LEXIS 10465 (D.D.C.1969).

§ 31-4431. Voting-trust agreements.

It shall be unlawful for any stockholder, director, or officer of any company having capital stock to enter into any contract or agreement, commonly known as "voting-trust agreements," whereby the rights, benefits, or liabilities attaching to the capital stock are transferred or assigned, temporarily or otherwise, to any person or group of persons, incorporated or unincorporated, for the purpose of controlling, managing, or directing the company, or voting its stock; provided, that this section shall not prevent the granting of proxies by stockholders authorizing a designated individual to represent them at stockholders' meetings.

(June 19, 1934, 48 Stat. 1151, ch. 672, ch. III, § 31.)

Prior Codifications. — 1981 Ed., § 35-631. 1973 Ed., § 35-531.

§ 31-4432. Maximum and contingent premiums of mutual companies. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1152, Ch. 672, ch. III, § 32; May 4, 1950, 64 Stat. 104, ch. 157, § 5.)

Prior Codifications. — 1973 Ed., § 35-532.

§ 31-4433. Classification of risks and members, payment of dividends, and creation of surplus by mutual companies.

A mutual company may, in its articles of incorporation or in its bylaws, provide for the classification of its risks and of its members and for the payment of dividends and for the creation of a surplus.

(June 19, 1934, 48 Stat. 1152, ch. 672, ch. III, § 33.)

Prior Codifications. — 1981 Ed., § 35-632. 1973 Ed., § 35-533.

§ 31-4434. Power of mutual company to borrow or assume liability.

(a)(1) In addition to the general power and authority to borrow money for its regular business purposes, if a domestic insurance company obtains prior written approval for a stated maximum amount, it may borrow money by the issuance of notes to:

- (A) Pay the reasonable expenses of its organization;
- (B) Provide contingency loss funds;
- (C) Provide additional surplus funds;
- (D) Satisfy a deficiency; or
- (E) Provide the amount of required minimum surplus.

(2) The notes issued for the purposes stated in paragraph (1) of this

subsection shall be known as surplus notes and shall fully recite the purpose for which the money was borrowed. The amount of the outstanding principal and unpaid interest of the surplus notes shall be stated in each annual report.

(b) The principal indebtedness of surplus notes issued on or after October 21, 2000, shall not be a liability or claim against any of the assets of the company. The principal of, and interest on, the notes may be paid from time to time, either in full or in part, from available surplus funds of the company only if the amount of the surplus of the company is twice the amount of principal and interest being paid. The company may make such payments whenever it is able to do so if it receives the prior written approval of the Commissioner. The Commissioner shall use the standards set forth in subchapter I of Chapter 7 of this title, relating to adequacy of surplus in determining whether or not to approve the payments. Upon a dissolution of the company, the principal and accrued and unpaid interest of the surplus notes shall be payable from surplus.

(June 19, 1934, 48 Stat. 1152, ch. 672, ch. III, § 34; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730; Oct. 21, 2000, D.C. Law 13-189, § 2, 47 DCR 7077; June 19, 2001, D.C. Law 13-313, § 13, 48 DCR 1873.)

Prior Codifications. — 1981 Ed., § 35-633. 1973 Ed., § 35-534.

Effect of amendments. — D.C. Law 13-189 rewrote this section which prior thereto provided: "A mutual company organized under chapters 3 to 8 1981 Ed. of this title may borrow or assume a liability for the repayment of a sum of money sufficient to defray the reasonable expenses of its organization or to enable it to comply with any requirement of the law or as a guaranty fund upon agreement, which shall first be submitted to and approved by the Commissioner, that such loan or advance, with interest at a rate not exceeding 6% per annum, shall be repaid out of the earnings, or profits of such corporation with the approval of the Commissioner whenever in his judgment the financial condition of the company shall warrant; but such approval shall not be withheld if, after such repayment shall be made, the company shall have and be in possession of a surplus equal to 10% or more of its gross annual premiums. Any such loan or advance shall not form a part of the legal liabilities of the company, but until repaid all statements published by such company or filed with the Commissioner shall show the amount thereof then remaining unpaid."

D.C. Law 13-313 substituted "prior written approval" for "prior approval" in the third sentence of subsec. (b).

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 13-189. — Law 13-189, the "Surplus Note Amendment Act of 2000," was introduced in Council and assigned Bill No. 13-677, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 2, 2000, it was assigned Act No. 13-405 and transmitted to both Houses of Congress for its review. D.C. Law 13-189 became effective on October 21, 2000.

Legislative history of Law 13-313. — Law 13-313, the "Technical Amendment Act of 2000," was introduced in Council and assigned Bill No. 13-879, which was referred to the Committee on the Whole. The Bill was adopted on first and second readings on December 5, 2000, and December 19, 2000, respectively. Signed by the Mayor on January 19, 2001, it was assigned Act No. 13-574 and transmitted to both Houses of Congress for its review. D.C. Law 13-313 became effective on June 19, 2001.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4435. Investments and loans. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1152, ch. 672, ch. III, § 35; Feb. 3, 1938, 52 Stat. 26, ch. 13, § 12; June 19, 1948, 62 Stat. 480, ch. 503; July 19, 1954, 68 Stat. 494,

ch. 546, § 1; Sept. 21, 1959, 73 Stat. 598, Pub. L. 86-329, § 1; Sept. 8, 1960, 74 Stat. 866, Pub. L. 86-731, § 1; Sept. 14, 1961, 75 Stat. 514, Pub. L. 87-245, § 1; Oct. 3, 1962, 76 Stat. 715, Pub. L. 87-739, § 1; Aug. 31, 1964, 78 Stat. 765, Pub. L. 88-566, § 2(a), (b); Aug. 14, 1973, 87 Stat. 303, Pub. L. 93-89, title II, § 201(3), (4); Oct. 30, 1981, D.C. Law 4-50, § 2, 28 DCR 4258; June 13, 1990, D.C. Law 8-141, § 2, 37 DCR 2654; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(e)(2), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-634. 1973 Ed., § 35-535.

Legislative history of Law 4-50. — Law 4-50, the “District of Columbia Local Business Investment Act of 1981,” was introduced in Council and assigned Bill No. 4-137, which was referred to the Committee on Housing and Economic Development. The Bill was adopted on first and second readings on July 14, 1981, and July 28, 1981, respectively. Signed by the Mayor on August 6, 1981, it was assigned Act No. 4-77 and transmitted to both Houses of Congress for its review.

Legislative history of Law 8-141. — Law 8-141, the “African Development Bank and Asian Development Bank Investment Amendment Act of 1990,” was introduced in Council and assigned Bill No. 8-127, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and

second readings on March 13, 1990, and March 27, 1990, respectively. Signed by the Mayor on April 17, 1990, it was assigned Act No. 8-197 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

Editor’s notes. — The reference to “§ 3701 et seq. of Title 38, United States Code” appearing in (a)(4)(H) was translated from § 1801 et seq., which originally appeared, as this section was renumbered in the U.S. Code.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4436. Domestic company real-estate holdings. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1153, Ch. 672, ch. III, § 36; June 19, 1948, 62 Stat. 480, ch. 503.)

Prior Codifications. — 1973 Ed., § 35-536.

§ 31-4437. Reinsurance by domestic companies in authorized companies. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1154, Ch. 672, ch. III, § 37; Oct. 15, 1993, D.C. Law 10-36, § 6(a), 40 DCR 5812, as amended, May 16, 1995, D.C. Law 10-255, § 26(c), 41 DCR 5193.)

Prior Codifications. — 1981 Ed., § 35-635. 1973 Ed., § 35-537.

§ 31-4438. Reinsurance of risks. [Repealed].

Repealed.

(Oct. 15, 1993, D.C. Law 10-36, § 6(a), 40 DCR 5812, as amended, May 16, 1995, D.C. Law 10-255, § 26(c), 41 DCR 5193.)

Prior Codifications. — 1981 Ed., § 35-635.

Legislative history of Law 10-36. — Law 10-36, the “Law on Credit for Reinsurance Act of 1993,” was introduced in Council and assigned Bill No. 10-128, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on July 29, 1993, it was assigned Act No. 10-69 and transmitted to both Houses of Congress for its review. D.C. Law 10-36 became effective on October 15, 1993.

Legislative history of Law 10-255. — Law 10-255, the “Technical Amendments Act of 1994,” was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

§ 31-4439. Vouchers or affidavits as evidence of disbursements.

No domestic company shall make any disbursement of \$100 or more unless the same be evidenced by a voucher signed by or on behalf of the person, firm, or corporation receiving the money and describing the consideration for the payment; and if the expenditure be in connection with any matter pending before any legislative or public body or before any department or officer of any state or government, the voucher shall describe the nature of the matter and the interest of the company therein, or, if such voucher cannot be obtained, the expenditure shall be evidenced by affidavit describing its character and object and stating the reasons for not obtaining such voucher.

(June 19, 1934, 48 Stat. 1154, ch. 672, ch. III, § 38.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-636. 1973 Ed., § 35-538.

§ 31-4440. Manner of keeping books, records, accounts, and vouchers.

Every domestic company shall keep its books, records, accounts, and vouchers in such manner that its financial condition can be ascertained and so that its financial statements filed with the Commissioner can be readily verified.

(June 19, 1934, 48 Stat. 1154, ch. 672, ch. III, § 39; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 24(c), 45 DCR 745.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Managing general agents, retention of contract records, see § 31-1503.

Prior Codifications. — 1981 Ed., § 35-637.

1973 Ed., § 35-539.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4410.

§ 31-4441. Acquisition of own capital stock. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1154, ch. 672, ch. III, § 40; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 24(d), 45 DCR 745; Apr. 11, 2003, D.C. Law 14-297, § 401(e)(2), 50 DCR 330.)

Prior Codifications. — 1981 Ed., § 35-638. 1973 Ed., § 35-540.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4410.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

§ 31-4442. Variable or modified guaranteed contracts.

(a) Every domestic life insurance company which issues contracts providing for payments which vary directly according to investment experience shall establish 1 or more separate accounts in connection with such contracts, as directed by the Commissioner. All amounts received by the company which are required by contract to be applied to provide such variable payments shall be added to the appropriate separate account, and the assets of any such separate account shall not be chargeable with liabilities arising out of any other business the company may conduct. Any surplus or deficit which may arise in any such separate account by virtue of mortality experience shall be adjusted by withdrawals from or additions to such account so that the assets of such account shall always equal the assets required to satisfy the company's obligations for such variable payments.

(a-1) Every domestic life insurance company that issues modified guaranteed contracts may establish 1 or more separate accounts in connection with these types of contracts. All amounts received by the company to provide benefits under contracts for which separate accounts have been established shall be added to the appropriate separate account. Amounts allocated by the company to separate accounts for modified guaranteed contracts shall be owned by the company, the assets therein shall be the property of the company, and no company by reason of such account shall be or hold itself out to be a trustee. The assets of any such separate account shall not be chargeable with liabilities arising out of any other business the company may conduct. For the purposes of this section, the term:

(1) "Modified guaranteed annuity" means any group or individual contract for an annuity in which the benefits are guaranteed if held for specified periods and nonforfeiture values are based upon a market-value adjustment formula if held for shorter periods. The formula may or may not reflect the investment experience of any separate account. The assets underlying the annuity contract must be maintained by the insurance company in a separate account during the period, or periods, when the annuity becomes payable.

(2) "Modified guaranteed contracts" means a modified guaranteed annuity or modified guaranteed life insurance policy or contract.

(3) "Modified guaranteed life insurance" means any group or individual policy of life insurance, the underlying assets of which are held in a separate account, in which the benefits are guaranteed if held for specified periods and nonforfeiture values are based upon a market-value adjustment formula if

held for shorter periods. The formula may or may not reflect the investment experience of any separate account. The assets underlying the policy must be maintained by the insurance company in a separate account during the period, or periods, when the policyholder can surrender the policy.

(b) A foreign or alien life insurance company authorized to do business in the District may be authorized to issue or deliver contracts in the District providing for payments which vary directly according to investment experience only if authorized to issue such contracts under the laws of its domicile.

(c) No domestic life insurance company shall be authorized to issue such variable contracts or modified guaranteed contracts, and no foreign or alien life insurance company shall be authorized to issue or deliver such contracts in the District, until such company has satisfied the Commissioner that its condition and methods of operation in connection with the issuance of such variable contracts or modified guaranteed contracts will not be such as to render its operation hazardous to the public or to its policyholders in the District. In determining the qualification of a company to issue or deliver such variable contracts or modified guaranteed contracts in the District, the Commissioner shall consider, among other things, the history and financial condition of the company; the character, responsibility, and general fitness of the officers and directors of the company; and, in the case of a foreign or alien company, whether the regulation provided by the laws of its domicile provides a degree of protection to policyholders and the public substantially equal to that provided by this section and the rules and regulations issued by the Commissioner pursuant thereto.

(d) Every life insurance company which issues or delivers such variable contracts or modified guaranteed contracts in the District shall file with the Commissioner, in addition to the annual statement required by § 31-4307 [repealed], such other periodic or special reports as the Commissioner may prescribe.

(e) The provisions of this section shall not apply to any contracts which do not provide for payments which vary directly according to investment experience other than modified guaranteed contracts and shall not apply to contracts issued pursuant to subsection (l) of this section.

(f) The Commissioner shall have the authority to issue such reasonable rules and regulations as may be necessary to carry out the purposes of this section.

(g) Repealed.

(h) Unless otherwise approved by the Commissioner, separate accounts relating to modified guaranteed contracts will be subject to investment laws applicable to a life insurance company's general asset account.

(i) Any modified guaranteed contract delivered or issued for delivery in the District, and any certificate evidencing nonforfeiture benefits that vary according to market-value adjustment formula issued pursuant to any life insurance or annuity contract issued on a group basis shall contain, on its first page, a prominent statement that the nonforfeiture value may increase or decrease, based on the market-value adjustment formula in the contract, and, for modified guaranteed life insurance only, be accompanied by a written disclo-

sure to the purchaser of the policy's interest adjusted net cost index in compliance with regulations or forms approved by the Commissioner.

(j) To the extent necessary to comply with the Investment Company Act of 1940, (15 U.S.C. § 80a-1 et seq.) as now or later amended, or any rules issued thereunder, the insurance company may adopt special procedures for the conduct of the business and affairs of the modified guaranteed contract separate accounts, and may, for persons having beneficial interests therein, provide special voting and other rights, including special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee, the members of which need not be otherwise affiliated with the corporation, to manage the business and affairs of the account.

(k) Reasonable actuarial expenses incurred in connection with approval of a modified guaranteed contract shall be paid by the person seeking approval of such a contract.

(l)(1) Every domestic life insurance company which issues modified guaranteed contracts in connection with a pension, retirement, or profit sharing plan may, after adoption of a resolution by its board of directors and delivery of certification of that adoption to the Commissioner, establish 1 or more separate accounts in connection with these types of contracts. The contracts may provide for payments and nonforfeiture values which vary according to investment experience of the accounts, for guaranteed payments and nonforfeiture values, for payments and nonforfeiture values that are subject to a market value adjustment formula, or for any other type of payments or incidental benefits. Any income and any realized or unrealized gain or loss on each separate account established pursuant to this paragraph shall be credited to or charged against that separate account in accordance with the terms of the contract without regard to the other income, gains, or losses of the company. Amounts allocated to the separate account shall be owned by the company, the assets therein shall be the property of the company, and no company by reason of such account shall be or hold itself out to be trustee. Unless the contract provides otherwise, the assets of any such separate account shall not be chargeable with liabilities arising out of any other business the company may conduct.

(2) Repealed.

(June 19, 1934, ch. 672, ch. III, § 41; June 12, 1960, 74 Stat. 218, Pub. L. 86-520, § 1; Mar. 22, 1994, D.C. Law 10-95, § 2, 41 DCR 503; Apr. 9, 1997, D.C. Law 11-255, § 38, 44 DCR 1271; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730; Apr. 11, 2003, D.C. Law 14-297, § 401(e)(2), 50 DCR 330.)

Cross references. — Holding company subsidiaries, investment limitations, see § 31-702.

Prior Codifications. — 1981 Ed., § 35-639. 1973 Ed., § 35-541.

Effect of amendments. — D.C. Law 14-297 repealed subs. (g) and (l)(2).

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 3(b) of Modified Guaranteed Contracts

Temporary Amendment Act of 1993 (D.C. Law 10-85, March 19, 1994, law notification 41 DCR 1635).

Legislative history of Law 10-95. — Law 10-95, the "Modified Guaranteed Contracts Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-364, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted

on first and second readings on December 7, 1993, and January 4, 1994, respectively. Signed by the Mayor on January 21, 1994, it was assigned Act No. 10-172 and transmitted to both Houses of Congress for its review. D.C. Law 10-95 became effective on March 22, 1994.

Legislative history of Law 11-255. — Law 11-255, the “Second Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-905, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 24, 1996, it was assigned Act No. 11-519 and transmitted to

both Houses of Congress for its review. D.C. Law 11-255 became effective on April 9, 1997.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Legislative history of Law 14-297. — For Law 14-297, see notes following § 31-1371.01.

References in text. — “Section 31-4307,” referred to in (d), was repealed by D.C. Law 10-42, § 7(b), 40 DCR 6020, effective October 21, 1993.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4443. Effect of merger or consolidation.

(a)(1) When a merger or consolidation has been completed, the merging or consolidating companies shall be a single company.

(2) For a merger, the single company shall be the 1 designated in the plan as the surviving company and, for a consolidation, shall be the new company described in the plan.

(b) The separate existence of the merging or consolidating companies shall cease.

(c) The surviving or new company shall have the rights, the privileges, the immunities, and the powers and shall be subject to the duties and liabilities of a life company organized under this subdivision.

(d)(1) The surviving or the new company shall have the rights, the privileges, the immunities, and the franchises of each of the merging or consolidating companies.

(2) All property interests, debts, claims, or other interests belonging to the merging or the consolidating companies shall be transferred automatically to the single company.

(3) Realty interests vested in the merging or the consolidating companies shall not revert or be impaired because of the merger or the consolidation.

(e)(1) The surviving or the new company shall be responsible for obligations of the merging or the consolidating companies.

(2) A claim involving 1 of the merging or consolidating companies may be litigated as though the merger or the consolidation had not taken place or with the single company replacing the merging or the consolidating company.

(3) Neither the rights of creditors nor any liens upon the property of a merging or consolidating company shall be impaired by the merger or the consolidation.

(f)(1) For a merger, the articles of incorporation of the surviving company shall be considered amended to the extent that the articles of merger described changes in the articles of incorporation.

(2) For a consolidation, articles of consolidation provisions required or permitted in the articles of incorporation of life companies shall be considered the articles of incorporation of the new company.

(g) The aggregate amount of the net assets of the merging or the consolidating companies available for the payment of dividends immediately before

the merger or the consolidation, to the extent that the amount cannot be transferred to stated capital, shall continue to be available for the payment of dividends by the surviving or the new company.

(June 19, 1934, ch. 672, ch. III, § 42, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Cross references. — Fraternal benefit societies, consolidations and mergers, see § 31-5311.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-640.

Legislative history of Law 5-160. — Law 5-160, the “Life Insurance Amendments Reform Act of 1984,” was introduced in Council

and assigned Bill No. 5-471, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 20, 1984, and December 4, 1984, respectively. Signed by the Mayor on December 7, 1984, it was assigned Act No. 5-225 and transmitted to both Houses of Congress for its review.

§ 31-4444. Procedure for merger of domestic companies.

(a) Two or more domestic life companies may merge into 1 company.

(b) The board of directors of each company shall, by resolution adopted by a majority vote of the members of the boards, approve a plan of merger that lists the following:

(1) The names of the companies proposing to merge.

(2) The name of the surviving company the merging companies would become.

(3) The terms and the conditions of the proposed merger.

(4) The manner and the basis of converting the shares or memberships of each merging company into:

(A) Shares, memberships, or other securities of the surviving company.

(B) Shares or other securities of another company.

(C) Cash or property.

(5) Changes in the articles of incorporation of the surviving company.

(6) Other provisions with respect to the proposed merger as are deemed necessary or desirable.

(June 19, 1934, ch. 672, ch. III, § 43, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-641.

Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

§ 31-4445. Procedure for consolidating domestic companies.

(a) Two or more domestic life companies may consolidate into a new company.

(b) To consolidate, the board of directors of each consolidating company, by resolution adopted by majority vote of the members of the boards, shall approve a plan of consolidation listing the following:

- (1) The names of the companies proposing to consolidate.
- (2) The name of the new company into which they propose to consolidate.
- (3) The terms and conditions of the proposed consolidation.
- (4) The manner and the basis of converting the shares or memberships of each company into:
 - (A) Shares, memberships, or other securities of the new company.
 - (B) Shares or other securities of another company.
 - (C) Cash or property.
- (5) The articles of incorporation for domestic companies organized under this chapter.
- (6) Other provisions with respect to the proposed consolidation as are deemed necessary or desirable.

(June 19, 1934, ch. 672, ch. III, § 44, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-642.

Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

§ 31-4446. Merger or consolidation of domestic and foreign companies.

(a) Foreign and domestic life companies may be merged or consolidated if the laws where each company is organized permit the merger or the consolidation.

(b) If the surviving or the new company is governed by a foreign jurisdiction, then the surviving or the new company shall comply with Chapter 45 of this subdivision, before transacting life insurance business in the District of Columbia.

(c) The surviving or the new company shall comply with § 31-202, and maintain and appoint in the District, or not more than 10 miles beyond the territorial limits of the District, an agent for service of process and shall register with the Commissioner the address of its principal office and the name and address of its agent for service of process in the District, including any changes in address.

(d) Repealed.

(e)(1) Except as provided in paragraph (2) of this subsection, a merger or a consolidation under this section shall be the same as a merger or a consolidation of domestic companies creating a surviving or a new company governed by the District of Columbia.

(2) If the surviving or the new company shall be governed by a foreign jurisdiction, the merger or the consolidation shall be the same as a merger or a consolidation of domestic companies except insofar as the laws of the foreign jurisdiction provide otherwise.

(June 19, 1934, ch. 672, ch. III, § 45, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39; Mar. 21, 1995, D.C. Law 10-233, § 3, 42 DCR 24; Apr. 18,

1996, D.C. Law 11-110, § 37, 43 DCR 530; May 21, 1997, D.C. Law 11-268, § 10(k), 44 DCR 1730.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-643.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of 1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 11-110. — Law 11-110, the “Technical Amendments Act of 1996,” was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1995, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4402.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4402.

§ 31-4447. Merger or consolidation — Approval by Mayor.

(a) The plan of merger or of consolidation and the filings required by § 31-5803 shall be mailed to shareholders, to members, or to policyholders of the domestic merging and consolidating companies, and shall be filed with the Mayor according to § 31-5803 [repealed].

(b) A life company aggrieved by the Mayor’s decision to disapprove a plan of merger or of consolidation with the Mayor under subsection (a) of this section shall have the rights, under § 31-5803 [repealed], to judicial review of the decision.

(June 19, 1934, ch. 672, ch. III, § 46, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-644.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443

References in text. — Section 31-5803, referred to in (a) and (b), was repealed by § 17 of D.C. Law 10-44, effective Oct. 21, 1993.

Editor’s notes. — Subsection (b) of this section is set forth above as it appears in D.C. Law 5-160. The word “filed” should probably appear following “consolidation.”

§ 31-4448. Merger or consolidation — Procedures before voting.

(a)(1) After approval from the Mayor, the board of directors shall, by resolution, direct that the plan of merger or of consolidation be voted upon at a meeting of the shareholders, the members, or the policyholders of record and entitled to vote.

(2) The vote may be conducted at either an annual or a special meeting.

(b) Written notice shall be delivered at least 20 days before the meeting, either personally or by mail, to each shareholder, member, or policyholder.

(c) The notice shall state the place, the time, and the purpose of the meeting, and a copy or a summary of the plan of merger or of consolidation shall be delivered with the notice.

(d) The notice shall also summarize dissenting shareholders' rights under § 31-4450.

(June 19, 1934, ch. 672, ch. III, § 47, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-645.

Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

§ 31-4449. Merger or consolidation — Approval by shareholders.

(a) The plan of merger or of consolidation shall be approved by the affirmative vote of the holders of two thirds of the voting outstanding shares of each company unless 2 or more classes of shares have been issued for any of the companies.

(b) If the company has issued 2 or more classes of shares, the plan of merger or of consolidation shall be approved by the affirmative vote of at least two thirds of the voting outstanding shares of each class.

(c) For a mutual company, each member or policyholder entitled to vote shall have 1 vote, regardless of the amount of insurance or number of policies held by the individual.

(June 19, 1934, ch. 672, ch. III, § 48, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39; Feb. 27, 1996, D.C. Law 11-90, § 11, 42 DCR 7155.)

Section references. — This section is referred to in §§ 31-3503 and 31-4450.

Prior Codifications. — 1981 Ed., § 35-646.

Emergency legislation. — For temporary amendment of section, see § 11 of the Insurance Omnibus Congressional Recess Emergency Amendment Act of 1995 (D.C. Act 11-97, July 19, 1995, 42 DCR 3844).

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

Legislative history of Law 11-90. — Law 11-90, the "Insurance Omnibus Amendment Act of 1995," was introduced in Council and assigned Bill No. 11-182, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1995, and December 5, 1995, respectively. Signed by the Mayor on December 18, 1995, it was assigned Act No. 11-173 and transmitted to both Houses of Congress for its review. D.C. Law 11-90 became effective on February 27, 1996.

§ 31-4450. Merger or consolidation — Rights of dissenting shareholders.

(a)(1)(A) If, by the date of shareholder meeting described in § 31-4449, a shareholder of a domestic merging or consolidating company files with the company a written objection to the merger or the consolidation and does not vote for the action and if, within 20 days after the merger or consolidation, the shareholder makes a written demand to the surviving or the new company for payment of the fair market value of the dissenting shareholder's shares, then

the surviving or new company shall pay the shareholder the value of the shares.

(B) The fair market value of the shares shall equal the market value on the day before the shareholders vote.

(2) The company shall make the payment when the dissenter surrenders the dissenter's certificate of share ownership.

(3) The demand shall state the number and the class of the shares owned by the dissenting shareholder.

(4) Any shareholders failing to make the demand described in subsection (1) of this section within the 20-day period shall have their interests in the company and their shares limited by the terms of the merger or consolidation.

(b)(1) If, within 30 days after the completion of the merger or consolidation, the dissenting shareholder and the surviving or new company agree upon the value of the shares, then the company shall pay the agreed upon value, according to subsection (a)(2) of this section, within 90 days after the merger or the consolidation becomes complete.

(2) When the company pays the agreed upon value, the dissenting shareholder shall cease having an interest either in the shares or in the company.

(c)(1) If, at the end of the 30-day period described in subsection (b)(1) of this section, the dissenting shareholder and the surviving or new company do not agree upon the value of the shares, then, within 60 days after the 30-day period ends, the dissenting shareholder may file a petition in the Superior Court of the District of Columbia asking for a determination of the fair value of the shares.

(2) The dissenter filing a timely petition shall be entitled to judgment against the surviving or new company for the amount the Court determines to be the fair value, and shall also be entitled to interest at the rate described in § 28-3302.

(3) The costs of the proceeding may be determined by the Court and may be apportioned by the Court against the parties.

(4) Some factors the Court may consider while making the apportionment described in paragraph (3) of this subsection shall be the following:

(A) Whether the fair value of the shares substantially exceeds the amount the company offered to pay.

(B) Whether the dissenting shareholder rejected the company's offer and brought the action in good faith.

(C) Whether the company failed to make an offer.

(5) The judgment shall be payable after the dissenting shareholder complies with subsection (a)(2) of this section.

(6) Any dissenting shareholder failing to petition within the 60-day period described in paragraph (1) of this subsection shall have his or her interests in the company and in his or her shares, as well as the interests of people claiming under the dissenter, limited by the terms of the merger or the consolidation.

(d) The right of a dissenter to receive the fair value for shares shall cease when the company abandons the merger or consolidation.

(June 19, 1934, ch. 672, ch. III, § 49, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in §§ 31-3503 and 31-4448.

Prior Codifications. — 1981 Ed., § 35-647.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

Editor's notes. — In D.C. Law 5-160, paragraph (2) of subsection (c) of this section was mistakenly set forth twice. This duplication error has been eliminated from the section as set forth above.

§ 31-4451. Articles of merger or consolidation.

(a) Upon shareholder approval of the merger or consolidation, articles of merger or consolidation shall be executed in duplicate by the president of each company, attested by the secretary of each company, and the corporate seal of each company shall be stamped on the articles.

(b) The articles shall list the following:

(1) The plan of merger or consolidation.

(2) For each company, the number of members, policyholders, or shares outstanding and, if 2 or more classes of shares have been issued, the designation of each class and the number of shares outstanding in each class.

(3) For each company, the number of members, policyholders, or shares voting for the plan and the number voting against the plan and, if 2 or more classes of shares have been issued, the number of shares of each class voting for the plan and the number voting against the plan.

(c)(1) The articles shall be filed with the Mayor.

(2) The Mayor shall charge a fee for filing the articles.

(3) If both the form of the articles and the fee payment comply with this section, then the Mayor shall perform the following:

(A) State the date of the filing and the word "filed" on the duplicates.

(B) Keep 1 of the duplicates.

(C) Send to the new or surviving company both the other duplicate and a certificate of merger or consolidation.

(June 19, 1934, ch. 672, ch. III, § 50, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Section references. — This section is referred to in §§ 31-3503 and 31-4452.

Prior Codifications. — 1981 Ed., § 35-648.

Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

§ 31-4452. Date merger or consolidation completed.

The merger or consolidation shall be complete when the Mayor issues under § 31-4451(c)(3)(C) the certificate of merger or consolidation to the new or surviving company.

(June 19, 1934, ch. 672, ch. III, § 51, as added Mar. 14, 1985, D.C. Law 5-160, § 3(c), 32 DCR 39.)

Cross references. — Insurance, merger or consolidation of life companies, new company governed by a foreign jurisdiction, compliance with this chapter, see § 31-4446.

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-649.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4443.

CHAPTER 45. FOREIGN AND ALIEN LIFE COMPANIES.

Sec.

31-4501. Filing requirements; approval by Commissioner of certain conditions.

Sec.

31-4502. Alien companies; trustees; examinations; financial statements.

§ 31-4501. Filing requirements; approval by Commissioner of certain conditions.

(a) A foreign or alien insurance company desiring to transact business in the District shall file with the Commissioner:

(1) Its application for certificate of authority, stating the kind or kinds of insurance it proposes to transact;

(2) A copy of its charter, articles of incorporation, or deed or settlement, certified by the official who is required to keep or record the same in the state under whose laws the company is incorporated, or if organized under the laws of a foreign government, province, or state, by the proper official of such government, province, or state;

(3) A copy of its bylaws, or regulations, if any, certified to by the secretary of the company;

(4) Copies of the policies it is issuing or proposes to issue and of the applications therefor;

(5) Proof of compliance with the service of process requirements of § 31-202; and

(6) A statement of its financial condition and business, in form as prescribed by law for annual statements, signed and sworn to by the president and secretary or other principal officers of the company. If an alien company, the statement shall comprise only its condition and business in the United States, and shall be signed and sworn to by its United States manager.

(b) It shall satisfy the Commissioner that the company is duly organized under the laws of the state, province, or government under whose laws it professes to be organized, and authorized to do the business it is transacting or proposes to transact, and that its name is not identical with, nor so similar to, that of another company organized prior to the organization of the applying company as to lead to confusion.

(c) It shall satisfy the Commissioner that its funds are invested in accordance with the laws of its domicile and in securities or property which afford a degree of financial security substantially equal to that required for similar domestic companies, and, if a stock company, that it has paid-up capital and surplus at least equal to the capital and surplus required of domestic stock companies, or, if a mutual company, that it has a surplus at least equal to that required by this subdivision for domestic mutual companies.

(June 19, 1934, 48 Stat. 1154, ch. 672, ch. IV, § 1; May 4, 1950, 64 Stat. 104, ch. 157, § 6; Mar. 21, 1995, D.C. Law 10-233, § 4, 42 DCR 24; May 21, 1997, D.C. Law 11-268, § 10(l), 44 DCR 1730.)

Cross references. — Application of chapter to existing companies, see § 31-4420.

Deposits of domestic companies, see § 31-4315 et seq.

Foreign or alien fraternal benefit society, admission, see § 31-5326.

Prior Codifications. — 1981 Ed., § 35-701. 1973 Ed., § 35-601.

Legislative history of Law 10-233. — Law 10-233, the “Insurers Service of Process Act of 1994,” was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Editor’s notes. — Department of Insurance abolished: The Department of Insurance, in-

cluding the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

§ 31-4502. Alien companies; trustees; examinations; financial statements.

The directors of an alien company may appoint citizens or corporations of the United States, approved by the Commissioner, as its trustees to hold funds and assets in trust for the benefit of the policyholders and creditors of the company in the United States. A certified copy of the record of such appointment and of the deed of trust shall be filed with the Commissioner, who may examine such trustees and any officers and agents, books, and papers of the company in the same manner as he may examine officers, agents, books, papers, and affairs of insurance companies. The funds and assets so held by such trustees shall, with the deposits otherwise made by the company and the funds and assets held by the company in the United States for the benefit of its policyholders and creditors in the United States, constitute the assets of the company for the purpose of making its financial statements required by this subdivision.

(June 19, 1934, 48 Stat. 1155, ch. 672, ch. IV, § 2; May 21, 1997, D.C. Law 11-268, § 10(l), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-702. 1973 Ed., § 35-602.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4501.

abolished: See Historical and Statutory Notes following § 31-4501.

Editor's notes. — Department of Insurance

CHAPTER 46. LIFE INSURANCE; PENALTIES; TESTIMONY; SEPARABILITY.

Sec.

31-4601. Violations.

31-4602. [Repealed].

Sec.

31-4603. Severability.

§ 31-4601. Violations.

Any person, partnership, or company who violates any of the provisions of this subdivision, or fails to comply with any duty imposed upon him or it by any provision of this subdivision, for which violation or failure no penalty is elsewhere provided by the laws of the District, shall be fined not exceeding \$500 for each and every violation. Civil fines, penalties, and fees may be imposed as alternative sanctions for any infraction of the provisions of this subdivision for which no penalty is provided elsewhere, or any rules or regulations issued under the authority of this subdivision, pursuant to Chapter 18 of Title 2. Adjudication of any infraction of this subdivision shall be pursuant to Chapter 18 of Title 2.

(June 19, 1934, 48 Stat. 1176, ch. 672, ch. VI, § 1; Oct. 5, 1985, D.C. Law 6-42, § 456, 32 DCR 4450.)

Cross references. — Application of chapter to existing companies, see § 31-4420.

Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-801. 1973 Ed., § 35-801.

Legislative history of Law 6-42. — Law 6-42, the “Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985,” was

introduced in Council and assigned Bill No. 6-187, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 25, 1985, and July 9, 1985, respectively. Signed by the Mayor on July 16, 1985, it was assigned Act No. 6-60 and transmitted to both Houses of Congress for its review.

§ 31-4602. Testimony; production of books; immunity of witness. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1176, Ch. 672, ch. VI, § 2; Oct. 13, 1970, Pub. L. 91-452, title II, § 254, 84 Stat. 931.)

Prior Codifications. — 1973 Ed., § 35-802.

§ 31-4603. Severability.

Should any section or provision of this subdivision be decided by the courts to be unconstitutional or invalid, the validity of this subdivision as a whole or of any part thereof other than the part decided to be unconstitutional shall not be affected.

(June 19, 1934, 48 Stat. 1177, ch. 672, ch. VI, § 3.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Prior Codifications. — 1981 Ed., § 35-802. 1973 Ed., § 35-803.

CHAPTER 47. PROVISIONS RELATING TO ALL LIFE INSURANCE COMPANIES.

Sec.	Sec.
31-4701. Valuation of reserves by Commissioner.	31-4713 to 31-4715. [Repealed].
31-4702. Companies issuing both participating and nonparticipating policies.	31-4716. Rights of parties under life policies.
31-4703. Life policies — Required provisions.	31-4716.01. Exemption from legal process — Disability benefits.
31-4704. Life policies — Prohibited provisions.	31-4717. Exemption from legal process — Group life policy or proceeds.
31-4705. Annuity and pure endowment contracts; forms to be filed and approved; required provisions; applications, riders and endorsements.	31-4718. [Repealed].
31-4705.01. Nonforfeiture benefits and cash surrender values.	31-4719. Authority to hold proceeds under trust or agreement.
31-4705.02. Standard nonforfeiture law — In general.	31-4720. Calculations of premiums and reserves.
31-4705.03. Standard nonforfeiture law — Individual deferred annuities.	31-4721. Acceptance and recordation of premiums on industrial life or sick-benefit policies.
31-4705.04. Loan provisions in policies.	31-4722. Industrial life policies — Required provisions.
31-4706. Extension of time for payment of premiums.	31-4723. Industrial life policies — Prohibited provisions.
31-4707. Ascertainment of loan indebtedness.	31-4724. Access to psychologists or optometrists under group health insurance policy.
31-4708. Filing and approval of life policy forms.	31-4725. Policy language simplification standards.
31-4709. Policy provisions required by foreign government entities.	31-4726. Commissioner's review of test.
31-4710. [Repealed].	31-4727. Applicability of §§ 31-4725 through 31-4730.
31-4711. Group policies — Required provisions.	31-4728. Regulations.
31-4711.01. Group policies — Right to, and notice of, issuance of individual policy.	31-4729. Construction of §§ 31-4725 through 31-4730.
31-4712. Accident and sickness policies.	31-4730. Operative dates of §§ 31-4725 through 31-4730.

§ 31-4701. Valuation of reserves by Commissioner.

(a)(1) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in the District, except that in the case of an alien company such valuation shall be limited to its insurance transactions in the United States, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest and methods (net level premium method or other) used in the calculation of such reserves. All such valuations made by him or by his authority shall be made upon the net premium basis. In calculating such reserves, he may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, he may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the Commissioner when such certificate states the valuation to have been made in a specified manner according to which the

aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(2) Any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to a minimum standard herein provided may, with the approval of the Commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided.

(b)(1) This subsection shall apply to only those policies and contracts issued prior to the operative date of § 31-4705.02 (the standard nonforfeiture law).

(2) The legal minimum standard for the valuation of life insurance contracts issued before January 1, 1935, shall be the method and basis of valuation heretofore applied by the Commissioner in the valuation of such contracts, and for life insurance contracts issued on and after said date shall be the 1-year preliminary term method of valuation, except as hereinafter modified, on the basis of the American Experience Table of Mortality with interest at 3 ½% per annum; provided, that any life company may, at its option, value its insurance contracts issued on and after January 1, 1935, in accordance with their terms on the basis of the American Men Ultimate Table of Mortality with interest not higher than 3 ½% per annum by the level net premium method or by the modified preliminary term method hereinafter described.

(3) If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than 20 years from date of the policy, or under an endowment preliminary term policy, exceeds that charged for like insurance under 20-payment life preliminary term policies of the same company, the reserve thereon at the end of the year, including the 1st, shall not be less than the reserve on a 20-payment life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period, equal to the difference between the value at the end of such period of such a 20-payment life preliminary term policy and the full net level premium reserve at such time of such a limited payment life or endowment policy. The premium payment period is the period during which premiums are concurrently payable under such 20-payment life preliminary term policy and such limited payment life or endowment policy.

(4) Policies issued on the preliminary term method shall contain a clause specifying that the reserve thereof shall be computed in accordance with modified preliminary term method of valuation provided for herein.

(5) Except as otherwise provided in paragraph (3) of subsection (c) of this section for group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities issued on and after January 1, 1935, shall be McClintock's Table of Mortality Among Annuitants, with interest at 4% per annum, but annuities deferred 10 or more years and written in connection with life insurance shall be valued on the same basis as that used in computing the consideration or premium therefor, or upon any higher standard at the option of the company.

(6) The legal minimum standard for the valuation of industrial policies issued after January 1, 1935, shall be the American Experience Table of Mortality with interest at 3 ½% per annum; provided, that any life company may voluntarily value its industrial policies on the basis of the standard industrial mortality table or the substandard industrial mortality table by the level net premium method or in accordance with their terms by the modified preliminary term method hereinbefore described.

(7) The Commissioner may vary the standards of interest and mortality in the case of alien companies as to contracts issued by such companies in countries other than the United States, and in particular cases of invalid lives and other extra hazards.

(8) Reserves for all such policies and contracts may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by this subsection.

(c)(1) This subsection shall apply to only those policies and contracts issued on or after the operative date of § 31-4705.02 (the standard nonforfeiture law) except as otherwise provided in paragraph (3) of this subsection for group annuity and pure endowment contracts issued prior to such operative date.

(2) Except as otherwise provided in paragraph (3) of this subsection and subsection (d) of this section, the minimum standard for the valuation of all such policies and contracts shall be the Mayor's reserve valuation methods defined in paragraphs (4) and (5) of this subsection and in § 31-4720, 3 ½% interest per annum, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after the October 13, 1978, 4 ½% interest per annum, and the following tables:

(A) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of paragraph (5) of § 31-4705.02(d), and the Commissioners 1958 Standard Ordinary Mortality Table for category of the policies issued on or after the operative date of the 5th paragraph in § 31-4705.02(d) and before the operative date for the category of policies described in § 31-4705.02(e); provided that for any category of such policies issued on female risks all modified net premiums and present values referred to in this section may be calculated according to an age not more than 6 years younger than the actual age of the insured and for any category of the policies issued on or after the operative date for the category described in § 31-4705.02(e), the Commissioners 1980 Standard Ordinary Mortality Table, or at the election of the company for any 1 or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors or any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the policies;

(B) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table for such policies issued prior to

the operative date of paragraph (6) of subsection (d) of § 31-4705.02, and for such policies issued on or after such operative date; provided, that for any category of such policies issued on female risks and evaluated by either the 1941 Standard Industrial Mortality Table or the Commissioners 1961 Standard Industrial Mortality Table, all modified net premiums and present values referred to in this section may be calculated according to an age not more than 6 years younger than the actual age of the insured, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the policies;

(C) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these Tables approved by the Commissioner;

(D) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such Table approved by the Commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(E) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(F) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standards for valuing the policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Intercompany Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Intercompany Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; or

(G) For group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the Commissioner.

(3)(A) Except as provided in subsection (d) of this section, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the Mayor's reserve valuation methods defined in paragraphs (4) and (5) of this subsection and the following tables and interest rates:

(i) For individual single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the contracts, or any modification of the tables approved by the Commissioner and 7 $\frac{1}{2}$ % interest per annum;

(ii) For individual annuity and pure endowment contracts, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the contracts, or any modification of the tables approved by the Commissioner and 5 $\frac{1}{2}$ % interest per annum for single premium deferred annuity and pure endowment contracts and 4 $\frac{1}{2}$ % interest per annum for all other such individual annuity and pure endowment contracts; or

(iii) For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum standard for valuing the annuities and the pure endowments, or any modification of the tables approved by the Commissioner and 7 $\frac{1}{2}$ % interest per annum.

(B) After October 13, 1978, any company may file with the Commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such company, provided, a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this paragraph for such company shall be January 1, 1979.

(4)(A) Except as provided in paragraph (5) of this subsection and in § 31-4720, and according to the reserve valuation method, reserves for life insurance and endowment benefits from policies providing uniform amounts of insurance and requiring uniform premium payments shall be the excess of the present value, on the valuation date, of the future guaranteed benefits from the policies over the then present value of any future modified net premiums.

(B) The modified net premiums shall be a uniform percentage of the respective premiums that makes the present value, on the issuance date, of all

modified net premiums equal the sum of the then present value of the benefits and the excess of the amount described in sub-subparagraph (i) of this subparagraph over the amount described in sub-subparagraph (ii) of this subparagraph.

(i) Except as provided in subparagraph (C) of this paragraph, a net level annual premium equal to the present value, on issuance date, of the benefits provided after the first policy year, divided by the present value, on issuance date, of an annuity of one per year to be paid on every anniversary of the policy for which a premium becomes due.

(ii) A net 1-year term premium for the benefits provided in the first policy year.

(C) The net level annual premium described in subparagraph (B)(i) of this paragraph shall not exceed the net level annual premium or the 19-year premium whole life plan for insuring the same amount at an age one year higher than the age at issuance in the policy.

(4A)(A) This paragraph governs life insurance policies issued after December 31, 1986, when the policies have the following features:

(i) The premium for the first year of the life insurance policy exceeds the premium for the second year.

(ii) The policy does not provide an additional benefit in the first year of the policy for the amount that the 1st-year premium exceeds the premium for the second year.

(iii) The policy provides an endowment benefit or a cash surrender value that exceeds the difference in the first year and the second year premiums.

(B) Except as provided in § 31-4702, and according to the reserve valuation method on any policy anniversary that takes place no later than the 1st year after a life insurance policy provides an endowment benefit or a cash surrender value that, together, exceeds the difference in the premiums described in subparagraph (A)(i) of this paragraph, the reserve shall be the greater of the following amounts:

(i) The reserve on the policy anniversary as described in paragraph (4) of this subsection.

(ii) The reserve on the policy anniversary as described in paragraph (4) of this subsection, but with the amount described in paragraph (4)(B)(i) of this subsection reduced by 15% of the excess first year premium, with present values of benefits and premiums determined without reference to premiums or benefits after the first year after a life insurance policy provides an endowment benefit or a cash surrender value that, together, exceeds the difference in the premiums described in subparagraph (A)(i) of this paragraph, with an assumption that the policy will mature as an endowment on that date; and with the cash surrender value provided on that date regarded as an endowment benefit.

(C) For the comparison described in subparagraph (B) of this paragraph, the mortality and interest bases described in paragraphs (3) and (4) of this subsection and in subsection (d)(2) and (3) of this section shall apply.

(5)(A) This paragraph shall apply to all annuity and pure endowment contracts except those group annuity and pure endowment contracts for which

reserves are to be calculated by a method consistent with the principles of paragraph (4) of this subsection.

(B) Reserves according to the Mayor's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation consideration derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(6) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated according to the method described in paragraph (4) of this subsection, in subsection (e) of this section, in § 31-4720, and in the mortality tables and rates of interest used to calculate nonforfeiture benefits for the policies.

(7) Reserves for any category of policies, contracts, or benefits, as established by the Commissioner, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.

(d)(1) The calendar year statutory valuation interest rates shall be the interest rates used to determine the minimum standard for valuing the following:

(A) Life insurance benefits under § 31-4705.02 and issued no earlier than the operative date for policies under § 31-4705.02(e).

(B) All annuities and pure endowments purchased under group annuity and pure endowments contracts after December 31, 1983.

(C) Except as provided in subparagraphs (A) and (B) of this paragraph, all life insurance benefits, individual annuity contracts, and pure endowment contracts issued after December 31, 1983.

(D) In a calendar year following December 31, 1983, the net increase of amounts held under guaranteed interest contracts.

(2) The calendar year statutory valuation interest rates shall be determined according to the equations described in this paragraph, and the results from the equations shall be rounded to the nearest $\frac{1}{4}\%$.

(A) For life insurance, the equation for determining the calendar year statutory valuation interest rates is the following:

$$I = .03 + W (R - .03) + {}^w/2 (R2 - .09).$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W (R - .03)$$

where $R/1$ is the lesser of R and $.09$,

$R/2$ is the greater of R and $.09$,

R is the reference interest rate described in paragraph (4) of this subsection,

and W is the weighting factor.

(C) Where cash settlement options are valued on an issue year basis, the formula in subparagraph (A) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration exceeding 10 years and the formula in subparagraph (B) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less.

(D) Where no cash settlement options apply, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply.

(E) Where cash settlement options are valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply.

(F)(i) If the calendar year statutory valuation interest rate for life insurance policies for a calendar year differs from the actual interest rate for similar policies issued in the preceding calendar year by less than $\frac{1}{2}\%$, the calendar year statutory valuation interest rate shall equal the corresponding actual interest rate for the preceding calendar year.

(ii) The calendar year statutory valuation interest rate shall be determined for each calendar year regardless of when § 31-4705.02(e) becomes operative.

(3) The weighting factors in the paragraph (2)(A) and (B) of this subsection equations are as follows:

(A) Weighting factors for life insurance:

<i>Guarantee Duration (Years)</i>	<i>Weighting Factors</i>
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, which are guaranteed in the original policy.

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options: .80.

(C) Except as provided in subparagraph (B) of this paragraph, weight-

ing factors for other annuities and for guaranteed interest contracts shall be specified in the following sub-subparagraphs:

(i) For purposes of this subsection, the following plan types apply:

“Plan Type A” means that, unless the company prohibits a withdrawal, the policyholder may withdraw funds with an adjustment to reflect changes in interest rates or asset values since the company received the funds; without adjustment, but in installments for 5 years or more; or as an immediate life annuity.

“Plan Type B” means that, before the interest rate guarantee expires, and unless the company prohibits a withdrawal, the policyholder may withdraw funds with an adjustment to reflect changes in interest rates or asset values since the company received the funds; without the adjustment, but in installments for 5 years or more; or, after the interest rate guarantee ends, in a lump sum without the adjustment or in installments lasting less than 5 years.

“Plan Type C” means that, before the interest rate guarantee expires, the policyholder may withdraw funds in a lump sum or in installments lasting less than 5 years, and either without the withdrawal being adjusted to reflect changes in interest rates or asset values since the company received the funds or with the withdrawal subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(ii) Weighting factors for annuities and guaranteed interest contracts valued on an issue year basis:

5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35.

(iii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in sub-subparagraph (ii) of this subparagraph increased by:

<i>Plan Type</i>		
<i>A</i>	<i>B</i>	<i>C</i>
.15	.25	.05.

(iv) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) and which do not guarantee interest on considerations received more than one year after issue or purchase, and for annuities and guaranteed interest contracts valued on a change in fund basis and which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in sub-subparagraph (ii) of this subparagraph or derived in sub-subparagraph (iii) of this subparagraph increased by:

<i>Plan Type</i>		
<i>A</i>	<i>B</i>	<i>C</i>
.05	.05	.05.

(v) Where cash settlement options apply to annuities and guaranteed

interest contracts, the guarantee duration is the number of years that the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years.

(vi) Where no cash settlement options apply to annuities or guaranteed interest contracts, the guarantee duration is the number of years from the issuance or the purchase date that the policy has scheduled the annuity benefits to begin.

(D)(i) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis.

(ii) Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis.

(iii) An issue year basis of valuation refers to a valuation basis where the interest rate used to determine the minimum valuation standard for the annuity or the guaranteed interest contract is the calendar year valuation interest rate for the issuance year or purchase year.

(iv) The change in fund basis of valuation refers to a valuation basis where the interest rate used to determine the minimum valuation standard for each change in the annuity or the guaranteed interest contract fund is the calendar year valuation interest rate for the year that the fund changed.

(4) The reference interest rate referred to in paragraph (2) of this subsection shall be as follows:

(A) For all life insurance, the reference rate shall be the lesser between the average rate during a 36-month period and the average rate during a 12-month period ending June 30 of the calendar year preceding the issuance year.

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising where cash settlement options apply to other annuities and to guaranteed interest contracts, the reference rate shall be the average rate during a 12-month period ending June 30 of the calendar year of issue or purchase.

(C) Where guarantee duration exceeds 10 years and where cash settlement options for annuities and for guaranteed interest contracts have values based upon the issuance year, the reference rate shall be the least between the average rate during a 36-month period and the average rate during a 12-month period ending June 30 of the calendar year of issue or purchase.

(D) Where guarantee duration does not exceed 10 years and where cash settlement options for annuities and for guaranteed interest contracts have values based upon the issuance year, the reference rate shall be the average rate during a 12-month period ending June 30 of the calendar year of issue or purchase.

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the reference rate shall be the average rate during a 12-month period ending June 30 of the calendar year of issue or purchase.

(F) Where cash settlement options apply to annuities and to guaranteed interest contracts and have values based on a change in the fund, the reference rate shall be the average rate during a 12-month period ending June 30 of the calendar year of the change in the fund.

(5)(A) Moody's Corporate Bond Yield Average—Monthly Average Corporate published by Moody's Investors Service, Inc., shall set the reference rates described in paragraph (4) of this subsection.

(B) If the National Association of Insurance Commissioners determines that Moody's Investors Service, Inc., is no longer an appropriate source for the reference rate, then an alternative method shall be adopted by the National Association of Insurance Commissioners and approved by the Commissioner.

(e) For life insurance plans which require the company to fix future premium determination according to the then present estimates of future experience, and for life insurance plans or annuities with minimum reserves that cannot be determined by the methods described in subsection (c)(5) and (6) of this section and in § 31-4720, the reserves held under the plan shall:

(1) Be appropriated in relation to the benefits and the pattern of premiums for the plan.

(2) Be computed by a method consistent with the principles of the Standard Valuation Law and according to regulations promulgated by the Commissioner.

(June 19, 1934, 48 Stat. 1156, ch. 672, ch. V, § 1; Feb. 19, 1948, 62 Stat. 27, ch. 66, § 1; June 27, 1960, 74 Stat. 227, Pub. L. 86-530, § 1; Oct. 3, 1962, 76 Stat. 711, Pub. L. 87-738, § 1; Oct. 13, 1978, D.C. Law 2-120, §§ 2, 3, 25 DCR 1519; Mar. 14, 1985, D.C. Law 5-160, § 3(d), 32 DCR 39; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Cross references. — Application of chapter to existing companies, see § 31-4420.

Domestic stock companies, conversion into mutual life companies, valuations, see § 31-4419.

Life insurance actuarial opinion of reserves and related actuarial items, requirements, see § 31-4901.

Section references. — This section is referred to in §§ 31-4705.02, 31-4720.

Prior Codifications. — 1981 Ed., § 35-501. 1973 Ed., § 35-701.

Legislative history of Law 2-120. — Law 2-120 was introduced in Council and assigned Bill No. 2-304, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on June 27, 1978, and July 11, 1978, respectively. Signed by the Mayor on August 2, 1978, it was assigned Act No. 2-250 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill

No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Editor's notes. — References in D.C. Law 5-160 in this section and in § 31-4720 have been translated accurately to reflect the D.C. Code numbering system for § 31-4701(c). It should be noted, however, that the numbering system used by the D.C. Code and the numbering system used by the Organic Law differ markedly.

Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorga-

nization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance

and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-4702. Companies issuing both participating and non-participating policies.

Every life company doing business in the District which issues both participating and nonparticipating policies shall keep the 2 classes of business separate and shall make, and include in the annual statement to be filed with the Commissioner each year, a separate statement of the gains, losses, and expenses properly attributable to each of such classes and also showing the manner in which any general outlay of expenses of the company has been apportioned to each. No such life company shall be permitted to do business in the District unless it makes such a separation of its business. This section shall not apply to paid-up, temporary, or pure endowment insurance issued or granted in exchange for lapsed or returned policies.

(June 19, 1934, 48 Stat. 1157, ch. 672, ch. V, § 2; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Section references. — This section is referred to in § 31-4701.

Prior Codifications. — 1981 Ed., § 35-502. 1973 Ed., § 35-702.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4703. Life policies — Required provisions.

(a) No life insurance policy other than industrial insurance, annuities, and pure endowments shall be issued or delivered in the District or shall be issued

by a life company organized under District laws after the 1st day of January, 1935, unless the policy has the following features:

(1) A provision that all premiums after the 1st year shall be payable in advance, either at the home office of the company or to an agent of the company, upon delivery of a receipt signed by 1 or more of the officers who shall be designated in the policy.

(2)(A) A provision that the insured is entitled to a grace period of at least 30 days or of 1 month within which the payment of any premiums after the 1st year may be made, subject at the option of the company to an interest charge not in excess of 6 per centum per year for the number of days of grace elapsing before the payment of the premium.

(B) A provision that, if the policy becomes a claim during the grace period before overdue or deferred premiums of the current policy year are paid, the amount of the premiums, with interest on any overdue premiums, may be deducted from any settlement payable under the policy.

(C) A provision that grace shall begin on the premium-paying date stated in the policy.

(3)(A)(i) Except as provided in subparagraphs (B) and (C) of this paragraph, a provision that the policy shall constitute the entire contract between the parties and shall be incontestable after it has been in force during the lifetime of the insured for at least 2 years from its date, except for nonpayment of premiums and except for violations of the conditions of the policy relating to naval or military service during a war, and at the option of the company, provisions relative to benefits when total and permanent disability occurs and provisions granting additional insurance specifically against death by accident may also be excepted.

(ii) All statements made by the insured shall, in the absence of fraud, be considered representations and not warranties.

(iii) No statements by the insured shall be used in defense of a claim under the policy unless the statements are in a written application and a copy of the statements are endorsed upon or attached to the policy when issued.

(B) A provision that nothing in this paragraph applies to applications for reinstatement.

(C) A provision that a reinstated policy shall be contestable for fraud or for misrepresenting material facts for as long a period as provided by the original policy.

(4) A provision that if the company discovers before the final settlement that the age of the insured (or the age of the beneficiary, if considered in determining the premium) has been wrongly stated, the amount payable under the policy shall be the amount the premium would have purchased had the correct age been stated, according to the company's rate at date of issue.

(5)(A)(i) A provision that the policy shall participate in the surplus of the company and that any policy containing provisions for participation at the end of the 1st policy year and afterwards may also provide that each dividend shall be paid subject to the payment of premium for the next year.

(ii) A provision that the insured under any annual dividend policy shall have the right each year to receive dividends from the participation paid in cash.

(iii) A provision that if the policy provides other dividend options, the policy shall explain which options shall be effective if the insured does not elect any of the other options by the end of the grace period allowed for paying the premium.

(B) A provision that the requirements described in subparagraph (A) of this paragraph shall not apply to any form of paid-up insurance, temporary insurance, or pure endowment insurance issued or granted in exchange for lapsed or surrendered policies and shall not apply to nonparticipating policies.

(6)(A)(i) Except as provided in subparagraphs (A)(iv), (v), and (B) of this paragraph, a provision that, after the policy has been in force for 3 full years, the company will loan to the insured, while the policy is in force, on proper assignment or pledge of the policy and on the sole security of the policy and at a specified interest rate, a sum equal to or, at the option of the insured, less than the amount required by § 31-4705.02.

(ii) A provision that the company will deduct from the loan value any indebtedness not already deducted when determining the value and any unpaid balance on premiums for the current policy year.

(iii) A provision that the company may collect, in advance, interest on the loan to the end of the current policy year.

(iv) The provisions described in subparagraph (A)(i) through (iii) of this paragraph shall not be required in term insurance, temporary insurance, or pure endowment insurance issued or granted in exchange for lapsed or surrendered policies. The policy may further provide that if the interest on the loan is not paid when due, it shall be added to the existing loan and shall bear interest at the same rate.

(v) The specified interest rate mentioned in subparagraph (A)(i) of this paragraph shall not apply to policies issued after March 14, 1985.

(B) Policies issued after March 14, 1985, shall include a provision describing the policy loan interest rates to be 1 of the following:

(i) Not more than 8% per year.

(ii) An adjustable maximum interest rate established by the company under subparagraph (C) of this paragraph.

(C) The interest rate described in paragraph (6)(B)(ii) of this subsection shall be in a policy which describes how frequently the company determines the rates, and the rates shall not exceed the higher of the following:

(i) The published monthly average for the calendar month ending 2 months before the company determines the interest rate; or

(ii) The sum of 1 per centum per year and the rate used by the company when computing the cash surrender value during the applicable period.

(D) For policies issued after March 14, 1985, which contain an interest rate determined pursuant to subparagraph (B)(ii) of this paragraph, the following provisions shall be included in the policy:

(i) The maximum interest rate shall be determined at least once every 12 months, at regular intervals, but not more frequently than once every 3 months.

(ii) The interest rate being charged may be increased when the

rate-determination standards described in subparagraph (C) of this paragraph indicate at least a $\frac{1}{2}\%$ per year increase in the maximum rate.

(iii) The interest rate being charged shall be decreased when the rate-determination standards described in subparagraph (C) of this paragraph require at least a $\frac{1}{2}\%$ per year decrease in the maximum rate.

(E) Except as provided in subparagraph (E)(v) of this paragraph and for policies issued after March 14, 1985, policies shall include a provision that the company shall notify, in the following manner, a policyholder who borrows under the policy:

(i) When the company makes a cash loan, a written notice of the initial interest rate.

(ii) When the company makes a premium loan, a written notice, within a reasonable time after the loan, of the initial interest rate.

(iii) When the company plans to increase the interest rate, a written notice within a reasonable time before the rate increase of the change in the rate.

(iv) Every notice described in this subparagraph shall describe how frequently the company, under subparagraph (C) of this paragraph, reevaluates the rates and also shall describe, under subparagraph (B) of this paragraph, the rates either as no more than 8% per year or as an adjustable rate under subparagraph (C) of this paragraph.

(v) Except as provided in subparagraph (E)(iii) of this paragraph, notice shall not be required for premium loans added to an original premium loan described in subparagraph (E)(ii) of this paragraph.

(F) The loan value of the policy shall be determined according to § 31-4705.04, but no policy shall terminate in a policy year as the sole result of change in the interest rate and the life insurer shall maintain coverage until the time at which it would otherwise have terminated if there had been no increase during that policy year.

(G) For purposes of subparagraphs (B) through (G) of this paragraph:

(i) The term “published monthly average” means Moody’s Corporate Bond Yield Average—Monthly Average Corporates published by Moody’s Investors Service, Inc., or any successor thereto; or in the event that Moody’s Corporate Bond Yield Average—Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Commissioner.

(ii) The rate of interest on policy loans permitted under this subsection also includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(iii) The term “policy loan” also includes any premium loan made under a policy to pay 1 or more premiums that were not paid to the life insurer as they fell due.

(iv) The term “policyholder” includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(v) The term “policy” also includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(H) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

(I) The provisions of subparagraphs (B) through (H) of this paragraph shall not apply to any insurance contract issued before March 14, 1985, unless the policyholder agrees in writing to the application of such provisions.

(7) A provision for nonforfeiture benefits and cash surrender values according to the requirements of § 31-4705.01 or § 31-4705.02.

(8) A provision specifying the options, if any, to which the policyholder is entitled in the event of default in a premium payment.

(9) A table showing in figures the loan values and the options available under the policy each year upon default in premium payments, during at least the first 20 years of the policy or during the premium paying period if less than 20 years.

(10) A provision that if in event of default in premium payments the value of the policy shall have been applied to the purchase of other insurance as provided for in this section, and if such insurance shall be in force and the original policy shall not have been surrendered to the company and cancelled, the policy may be reinstated within 3 years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums and the payment or reinstatement of any other indebtedness to the company upon said policy, with interest on said premium at the rate of not exceeding 6% per annum payable annually, and that such reinstated policy shall be contestable, on account of suicide, fraud, or misrepresentation of material facts pertaining to the reinstatement, for the same period after reinstatement as provided in the policy with respect to the original issue. The rate of interest on policy loans permitted under this subsection also includes the interest rate charged on reinstatement policy loans for the period during and after any lapse of the policy.

(11) A provision that, when a policy shall become a claim by death of the insured, settlement shall be made upon receipt of due proof of death.

(12) A table showing the amount of installments, if any, in which the policy may provide its proceeds may be payable.

(13) Title on the face and on the back of the policy briefly describing its form.

(b) Any of the foregoing provisions or portions thereof not applicable to single premium or nonparticipating or term policies shall, to that extent, not be incorporated therein; and any such policy may be issued or delivered in the District which in the opinion of the Commissioner contains provisions on any 1 or more of the several foregoing requirements more favorable to the policyholder than hereinbefore required. The provisions of this section shall not apply to policies of reinsurance, or to policies issued or granted in exchange for lapsed or surrendered policies, or to group insurance.

(June 19, 1934, 48 Stat. 1158, ch. 672, ch. V, § 3; Feb. 19, 1948, 62 Stat. 30, ch. 66, § 2; Oct. 13, 1978, D.C. Law 2-120, § 4, 25 DCR 1519, Mar. 14, 1985, D.C. Law 5-160, § 3(e), 32 DCR 39; Feb. 24, 1987, D.C. Law 6-192, § 25(a)-(d), 33 DCR 7836; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Cross references. — False statements in application, effect, see § 31-4314.

Special provisions governing industrial policies, see § 31-4801 et seq.

Section references. — This section is referred to in §§ 31-4705.01 and 31-4705.04.

Prior Codifications. — 1981 Ed., § 35-503. 1973 Ed., § 35-703.

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Legislative history of Law 6-192. — Law

6-192, the "Technical Amendments Act of 1986," was introduced in Council and assigned Bill No. 6-544, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 5, 1986, and November 18, 1986, respectively. Signed by the Mayor on December 10, 1986, it was assigned Act No. 6-246 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

CASE NOTES

ANALYSIS

Construction of policy provisions.
Effective dates.

Construction of policy provisions.

Life policy application and conditional receipt, each containing ambiguous provisions, would be resolved in favor of insured. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

Where application and conditional receipt were parts of contractual relationship leading to execution of formal life policy, they were to be examined to determine whether their provisions on effectiveness were reasonably susceptible of different interpretation or more than one meaning. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

Insurance company which chooses to enter into insurance contract impliedly consents to all reasonable conditions and regulations imposed on it by jurisdiction in which contract is made, including any statutory incontestability provisions, and provisions required by statute to be included in policy prevail over inconsistent terms in policy as written by the company. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

Effective dates.

To determine whether policy became effective on policy year date or date of issue, court would

look to provisions of contract and to actions and intent of parties in relation to such provisions. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

To define word "date" in insurance contract or statute as effective date of policy promotes purpose of statutory incontestability requirements, i.e., to protect insured by forbidding insurer's unilateral extension of contestable clause for period greater than two years from date of attachment of risk of loss; word "date" in District of Columbia incontestability statute thus referred to effective date of life insurance policy. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

Where premiums on life policy were paid on October 1, 1973 and monthly thereafter, and policy anniversaries were measured from such date and such date determined loan and cash values on policy, dividends, paid-up insurance, extended insurance and grace periods, October 1, 1973 was when policy became effective, rather than November 16, 1973, which was designated by policy as date of issue, and, under District of Columbia statute provide for incontestability after two years from date of policy, policy became incontestable two years from October 1, 1973. D.C. Code § 35-703(3). *Manufacturers Life Ins. Co. v. Capitol Datsun, Inc.*, 566 F.2d 354, 1977 U.S. App. LEXIS 10815 (C.A.D.C. 1977).

§ 31-4704. Life policies — Prohibited provisions.

No policy of life insurance other than industrial insurance, annuities, and pure endowments, with or without return of premiums or of premiums and interest, shall be issued or delivered in the District or be issued by a life company organized under the laws of the District after the 1st day of January 1935 if it contains any of the following provisions:

- (1) A provision limiting the time within which any action at law or in

equity may be commenced to less than 3 years after the cause of action shall accrue;

(2) A provision by which the policy shall purport to be issued or take effect more than 6 months before the original application for the insurance was made;

(3) Except for provisions relating to misstatement of age, suicide, aviation, and military or naval service in time of war, a provision for any mode of settlement at maturity, after the expiration of the contestable period of the policy, of less value than the amount insured on the face of the policy plus dividend additions, if any, less any indebtedness to the company on or secured by the policy, and less any premium that may, by the terms of the policy, be deducted. This paragraph shall not apply to any nonforfeiture provision;

(4) A provision for forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on such loan, while the total indebtedness on the policy, including interest, is less than the loan value thereof;

(5) A provision to the effect that the agent soliciting the insurance is the agent of the person insured under said policy, or making the acts or representations of such agent binding upon the person so insured under said policy;

(6) A provision permitting the payment of funeral benefits in merchandise or services, or permitting the payment of any benefits other than in lawful money of the United States; or

(7) A provision permitting either contracting to pay, or the payment of, funeral, burial, and other expenses to any designated undertaker or undertaking establishment, or to any particular tradesman or business man, so as to deprive the persons entitled by law to dispose of the body of a deceased, or in any way to control such persons in procuring and purchasing said supplies and services in the open market with the advantage of competition.

(June 19, 1934, 48 Stat. 1161, ch. 672, ch. V, § 4; Feb. 19, 1948, 62 Stat. 30, ch. 66, § 3.)

Prior Codifications. — 1981 Ed., § 35-504. 1973 Ed., § 35-704.

CASE NOTES

Military service.

Provisions in life policy limiting liability if death of insured resulted from military or naval service outside the United States in time of war and if death of insured resulted within two years from date of issue of policy from war while insured was outside the United States, were not, separately considered, ambiguous; but, where death of insured occurred in time of war while he was serving as a naval officer outside the United States more than two years after date of policy, both provisions applied and were conflicting, thus creating an ambiguity requiring construction against insurer. *Hayes v. Home Life Ins. Co.*, 168 F.2d 152, 1948 U.S. App. LEXIS 2022 (1948).

Provision in life policy, limiting liability if death of insured resulted within two years from

date of issue of policy from war while insured was outside the United States, was not only a limitation of liability for two years but an affirmation of full liability after two years, so far as war might be cause of death. *Hayes v. Home Life Ins. Co.*, 168 F.2d 152, 1948 U.S. App. LEXIS 2022 (1948).

Provisions in life policy limiting liability if death of insured resulted from military or naval service outside the United States in time of war, and if death of insured resulted within two years from date of issue of policy from war while insured was outside of the United States, were opposite in result after two years had expired and not alternative bars to liability. *Hayes v. Home Life Ins. Co.*, 168 F.2d 152, 1948 U.S. App. LEXIS 2022 (1948).

Under life policy limiting liability if death of

insured resulted from military or naval service outside the United States in time of war and if death of insured resulted within two years from date of issue of policy from war while insured was outside the United States, where death of insured occurred while he was serving as a naval officer outside of the United States in time of war and more than two years after date of policy, ambiguity between policy provisions would be resolved by applying the two year provision as an affirmation of liability. *Hayes v. Home Life Ins. Co.*, 168 F.2d 152, 1948 U.S. App. LEXIS 2022 (1948).

The President's Proclamation fixing date of cessation of hostilities in World War II, was for public purposes, and does not necessarily apply to private contracts. Proclamation No. 2714, 50 U.S.C.Appendix, § 601 Note. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

The words "engaged in war" in common speech mean actual warfare, terminated by capitulation of enemy forces. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

Whether United States is engaged in war is a political question, determination of which rests with the legislative and executive branches of government, and their pronouncements are binding on the judiciary, from the standpoint of public law, but from the standpoint of private law different considerations are involved. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

The phrase "cessation of hostilities," could not be interpolated in life policy restricting

liability in case of death of insured in military or naval forces of country engaged in war. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

Where terms of life policy were devised by insurer and contract was presented to insured in fixed form, and insurer failed to make it obvious that a phrase "engaged in war" in provision restricting liability was intended to connote a technical meaning, the phrase would be given the meaning which common speech imports. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

Where insured was fatally injured when he fell from hotel window in France on October 2, 1945, while serving with occupation forces, the United States was not a country "engaged in war" within life policy provision restricting liability, even though war had not terminated in a political sense. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

The United States was a country "engaged in war" on October 2, 1945, when insured met his death in France, while in military service of United States, within provision in life policy restricting payment to amount less than face value if insured's death occurred outside the home areas while he was in the military forces of any country "engaged in war", where there had been no proclamation by the executive that hostilities had ceased. *Stinson v. New York Life Ins. Co.*, 167 F.2d 233, 1948 U.S. App. LEXIS 2430 (1948).

§ 31-4705. Annuity and pure endowment contracts; forms to be filed and approved; required provisions; applications, riders and endorsements.

(a) On and after January 1, 1935, no annuity or pure endowment contract shall be issued or delivered in the District unless and until a copy of the form thereof has been filed with the Commissioner and formally approved by him.

(b) Except in the case of a reversionary annuity, otherwise called a "survivorship annuity," or an annuity contracted by an employer in behalf of his employees, no annuity or pure endowment contract shall be so issued or delivered in this District unless it contains, in substance, the following provisions:

(1) A provision that there shall be a period of grace, either of 30 days or of 1 month, within which any stipulated payment to the company falling due after the 1st year may be made, subject, at the option of the company, to an interest charge thereon at a rate to be specified in the contract, but not exceeding 6 per centum per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death during the said period of grace before the overdue payment to the company or

the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement;

(2) If statements, other than those relating to age and identity, are required, as a condition of issuing the contract, a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except where stipulated payments to the company have not been made, and except for violation of the conditions of the contract relating to military or naval service in time of war, and at the option of the company, provisions relative to benefits in the event of total and permanent disability and provisions which grant insurance specifically against death by accident may also be excepted;

(3) A provision that such contract shall constitute the entire contract between the parties, but if the company desires to make the application a part of the contract it may do so, provided a copy of such application shall be endorsed upon or attached to such contract, when issued, and in such case such contract shall contain a provision that it, together with the application therefor, shall constitute the entire contract between the parties;

(4)(A) A provision that if the age of the person or persons upon whose life or lives the contract is based, or of any of them, has been misstated, the amount payable under the contract shall be such as the stipulated payments to the company would have purchased at the correct age or ages; or

(B) Any overpayment or overpayments by the company, on account of misstatement of age, shall with interest thereon at a rate to be specified in the contract, but not exceeding 6 per centum per annum, be charged against the current or next-succeeding payment or payments to be made by the company under the contract;

(5) If the contract is participating, a provision that the divisible surplus shall be apportioned annually and dividends shall be payable in cash or shall be applicable to any stipulated payment or payments to the company under the contract;

(6) A provision specifying the options available in the event of cessation of payment of considerations under the contract. In the case of contracts issued on or after the operative date of § 31-4705.03 (the standard nonforfeiture law for individual deferred annuities), such options shall be in accordance with § 31-4705.03. In the case of contracts issued prior to the operative date of § 31-4705.03, such option shall provide that if the contract, after having been in force for 3 full years, shall, by its terms, lapse or become forfeited because any stipulated payment to the company shall not have been made, the reserve on such contract, computed according to the standard adopted by said company in accordance with this chapter, shall, after deducting one fifth of the said entire reserve, and any indebtedness to the company under the contract, be applied as a net single payment, according to said standard, for the purchase of a paid-up annuity or pure endowment contract, which may be nonparticipating and which shall be payable by the company under the same terms and conditions, except as to amount, as the original contract. For contracts issued

prior to the operative date of § 31-4705.03, a company may provide, in lieu of such paid-up values, for a paid-up annuity or pure endowment contract in an amount bearing the same proportion to the original annuity or pure endowment contract as the number of stipulated payments which shall have been made to the company shall bear to the total number of stipulated payments required to be made to the company under the contract, and if there be any indebtedness to the company under the contract, the amount of such paid-up annuity or pure endowment shall be reduced by an amount bearing the same proportion to such paid-up annuity or pure endowment as such indebtedness bears to the reserve on such paid-up annuity or pure endowment, computed according to the standard adopted by said company in accordance with this chapter; and

(7) A provision that the contract may be reinstated at any time within 1 year from the date of default in making stipulated payments to the company, provided that all overdue stipulated payments and any indebtedness to the company on the contract shall be made or paid, with interest thereon at a rate to be specified in the contract, but not exceeding 6% per annum, payable annually. In cases where applicable a company may also include a requirement of evidence of insurability satisfactory to the company.

(c) No contract for a reversionary annuity shall be so issued or delivered unless it contains in substance the following provisions:

(1) Paragraphs (1), (2), (3) and (5) of subsection (b) of this section, except that under paragraph (1) of subsection (b) of this section, the company may, at its option, provide for an equitable reduction of the amount of the annuity payments in settlement of any overdue or deferred payments, in lieu of providing for a deduction of such payments from any amount payable upon a settlement under the contract;

(2) A provision that, if the age of any of the persons upon whose lives the contract is based has been misstated, the amount payable under the contract shall be such as the stipulated payments to the company would have purchased at the correct ages; and

(3) A provision that the contract may be reinstated at any time within 3 years from the date of default in making stipulated payments to the company, upon production of evidence of insurability satisfactory to the company, provided that all overdue payments and any indebtedness to the company on the contract shall be made or paid, with interest thereon at a rate to be specified in the contract, but not exceeding 6 per centum per annum, payable annually.

(d) Any of the foregoing provisions or portions thereof not applicable to nonparticipating contracts nor to contracts for which a single stipulated payment to the company is made shall, to that extent, not be incorporated therein; and any such contract may be issued or delivered in this District, which, in the opinion of the Commissioner, contains provisions on any 1 or more of the several foregoing requirements, more favorable to the holder of the contract than hereinbefore required.

(e) Nothing herein contained shall be construed to prevent a life company, which issues life insurance on a participating basis, from issuing annuities, reversionary annuities, or pure endowments on a nonparticipating basis.

(f) Any such contract or any application, endorsement, or rider form used in connection therewith, issued in violation of this section, shall, nevertheless, be held valid, but shall be construed as provided in this section and when any provision in such contract, application, endorsement, or rider is in conflict with any provision of this section or with any other statutory provision, the rights, duties, and obligations of the company, of the holder of the contract and of the beneficiary or annuitant thereunder shall be governed by the provisions of this section.

(g) The provisions of this section shall not apply to contracts of reinsurance nor to contracts for deferred annuities or reversionary annuities included in life insurance policies.

(h) For the purposes of this section, application forms, rider forms, and endorsement forms for use in connection with any such contract, excepting riders or endorsements relating to the manner of distribution of benefits or to the reservation of rights and benefits under any such contract, and used at the request of the individual holders of such contracts, shall be deemed to be parts of such contract and shall require the approval of the Commissioner. No rider and no endorsement, except as stated above, shall be attached to or printed or stamped upon any such contract issued or delivered in the District until the form of such rider or endorsement has been filed with the Commissioner and formally approved by him.

(June 19, 1934, 48 Stat. 1161, ch. 672, ch. V, § 5; Oct. 13, 1978, D.C. Law 2-120, § 5, 25 DCR 1519; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Cross references. — Copy of application, required delivery with policy, see § 31-5203.

False statements in application, effect, see § 31-4314.

Industrial policies, special provisions governing, see § 31-4801 et seq.

Prior Codifications. — 1981 Ed., § 35-505. 1973 Ed., § 35-705.

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-47501.

References in text. — The “operative date of § 31-4705.03,” referred to throughout paragraph (b)(6) of this section, is prescribed by § (9)(b) of D.C. Law 2-120.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4705.01. Nonforfeiture benefits and cash surrender values.

(a) This section shall apply only to policies of life insurance issued prior to the operative date of § 31-4705.02 (the standard nonforfeiture law).

(b) The nonforfeiture benefits referred to in paragraph (7) of subsection (a) of § 31-4703 shall be available to the insured in event of default in premium payments, after premiums shall have been paid for 3 years, and shall be a stipulated form of insurance, effective from the due date of the defaulted premium, the net value of which shall be at least equal to the reserve at the date of default on the policy and on dividend additions thereto, if any, exclusive of the reserve on account of return premium insurance and on total and permanent disability and additional accidental death benefits (the policy to

specify the mortality table and rate of interest adopted for computing such reserve), less a specified percentage (not more than 2 ½) of the amount insured by the policy and of existing dividend additions thereto, if any, and less any existing indebtedness to the company on or secured by the policy; provided, that a company may, in lieu of the provision herein permitted for the deduction from the reserve of a sum not more than 2 ½% of the amount insured by the policy, and of any dividend additions thereto, insert in the policy a provision that one fifth of said reserve may be deducted, or may provide therein that a deduction may be made of said 2 ½% or one fifth of said reserve, at the option of the company; provided further, that the policy may be surrendered to the company at its home office within 1 month of the due date of defaulted premium for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as aforesaid; and provided further, that the company may defer payment for not more than 6 months after the application therefor is made. A provision may also be inserted in the policy that in event of default in a premium payment before such benefit becomes available, the reserve on any dividend additions then in force may at the option of the company be paid in cash or applied as a net premium to the purchase of paid-up term insurance for any amount not in excess of the face of the original policy. This section shall not apply to term insurance of 20 years or less. The net single premium rate employed in computing the term of temporary insurance or the amount of pure endowment insurance granted as a nonforfeiture value under any life insurance policy may at the option of the company be based upon a table of mortality showing rates of mortality not greater than 130 per centum of those shown by the American Men Ultimate Table of Mortality instead of the table used in computing the reserve on the policy, or in case of substandard policies not greater than 130 per centum of the rates of mortality shown by the table of mortality approved by the Commissioner for computing the reserve on the policy, anything herein to the contrary notwithstanding.

(June 19, 1934, ch. 672, ch. V, § 5a; Feb. 19, 1948, 62 Stat. 30, ch. 66, § 4; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Section references. — This section is referred to in §§ 31-4703 and 31-4722.

Prior Codifications. — 1981 Ed., § 35-506. 1973 Ed., § 35-705a.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

References in text. — The “operative date of § 31-4705.02,” referred to in subsection (a) of

this section, was prescribed by § 2 of the Act of October 3, 1962, 76 Stat. 712, Pub. L. 87-738, and was formerly codified as § 35-507(g) (1981 Ed.). Section 35-507 § 31-4705.02, 2001 Ed. was rewritten effective March 14, 1985, and no longer contains the “operative date” language.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4705.02. Standard nonforfeiture law — In general.

(a)(1) Except as provided in subsections (i) and (j) of this section and for policies issued after the operative date of this section, no life insurance policy shall be issued or delivered in the District of Columbia unless it contains the following provisions or corresponding provisions which the Commissioner

considers at least as favorable to the defaulting or surrendering policyholder as the following provisions;

(A)(i) If the insured defaults on a premium payment after premiums have been paid 1 full year for ordinary insurance or 3 full years for industrial insurance, the company shall grant, upon proper request no later than 60 days after the premium became due, a paid-up nonforfeiture benefit on a plan stipulated in the policy, and the paid-up nonforfeiture benefit shall be effective when the premiums became due.

(ii) The company may substitute for the nonforfeiture benefit described in subparagraph (A)(i) of this paragraph an actuarially equal alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or a greater amount or earlier payment of endowment benefits.

(B) If the insured defaults on a premium payment after ordinary insurance premiums have been paid for 3 full years or industrial insurance premiums have been paid for 5 full years and surrenders the policy within 60 days after the premiums became due, the company shall pay a cash surrender value instead of paying a paid-up nonforfeiture benefit.

(C) A specified paid-up nonforfeiture benefit shall become effective unless the person entitled to make an election chooses another available option no later than 60 days after the defaulted premium became due.

(D) If all premium payments become paid or if the company continues the policy under a paid-up nonforfeiture benefit which became effective after the eve of the 3rd policy anniversary for ordinary insurance or after the eve of the 5th policy anniversary for industrial insurance, and if the insured surrenders the policy within 30 days after any policy anniversary, the company will pay a cash surrender value.

(E)(i) For policies creating upon the guaranteed bases unscheduled changes in benefits or premiums or having an option for changes in benefits or premiums other than a change to a new policy, the policy shall describe or show the mortality table, the interest rate, and the method used to calculate cash surrender values and paid-up nonforfeiture benefits available under the policy.

(ii) For all other policies, the policy shall show the mortality table and the interest rate used to calculate the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value and paid-up nonforfeiture benefit available under the policy on each anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter, and with the values and benefits calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(F)(i) The policy shall provide a brief and general statement of the method to be used in calculating the cash surrender value and the paid-up nonforfeiture benefit available on any policy anniversary after the last anniversary treated in the policy according to the manner described in subparagraph (E)(ii) of this paragraph.

(ii) The brief statement shall explain how paid-up additions and

indebtedness on the policy changes the cash surrender values and the paid-up nonforfeiture benefits.

(2) Any subsection (a) provision that does not apply to the plan of insurance in a policy may be omitted from the policy to the extent that the provision does not apply.

(3) The company shall reserve the right to defer the payment of any cash surrender value until 6 months after payment has been demanded and until the insured has surrendered the policy.

(b)(1) Any cash surrender value available under subsection (a) of this section after a default on a premium due on a policy anniversary shall be at least the excess of the present value, on the anniversary, of the future guaranteed benefits which would have been provided by the policy and any existing paid-up additions, had there been no default, over the sum of the following:

(A) The then present value of the adjusted premiums described in subsections (d) and (e) of this section, corresponding to premiums which would have become due after the eve of the anniversary.

(B) The amount of any indebtedness to the company on the policy.

(2) For any policy issued after the operative date of subsection (e) of this section and which provides supplemental life insurance or annuity benefits at the option of the insured and for an additional premium by rider or by supplemental policy provision, the cash surrender value referred to in subsection (b)(1) of this section shall be at least the sum of the cash surrender value for an otherwise similar policy issued at the same age without the rider or the supplemental policy provision and the cash surrender value for a policy which provides only the benefits otherwise provided by the rider or the supplemental provision.

(3) For any family policy issued after the operative date of subsection (e) of this section and which defines a "primary insured" and provides term insurance on the life of the spouse of the primary insured for a period that shall expire before the spouse becomes 71, the cash surrender value referred to in subsection (b)(1) of this section shall be at least the sum of the cash surrender value for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and the cash surrender value for a policy which provides only the benefits otherwise provided by the term insurance on the life of the spouse.

(4) Any cash surrender value available within 30 days after any policy anniversary on a policy paid up by completion of all premium payments or a policy continued under a paid-up nonforfeiture benefit shall be at least the present value, on the anniversary, of the future guaranteed benefits provided by the policy and any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(c) Any paid-up nonforfeiture benefit available under a policy referred to in subsection (a) of this section after a default in a premium payment due on a policy anniversary shall be in a sufficient amount for the present value on the anniversary to be at least equal to the cash surrender value then provided by the policy or, if none is provided, the cash surrender value that would have

been required by this section in the absence of the condition that premiums shall be paid for at least a specified period.

(d)(1) This subsection shall not apply to policies issued after the operative date of subsection (e) of this section.

(2) Except as provided in paragraphs (2), (3), and (8) of this subsection, the adjusted premiums for any policy referred to in subsection (a) of this section shall be calculated on an annual basis and shall be a uniform percentage of the premiums for each policy year, excluding any extra premiums charged because of impairments or special hazards, and the adjusted premiums shall equal the sum of:

(A) The value, on the issuance date, of the future guaranteed benefits provided by the policy.

(B) Two per centum of the amount of insurance for uniform amounts of insurance or an equal amount for amounts of insurance that vary with the duration of the policy.

(C) Forty per centum of the adjusted premium for the 1st policy year.

(D) Twenty-five per centum of either the adjusted premium for the 1st policy year or the adjusted premium for a whole life policy of the same or equal uniform amount, with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(3) For the percentages described in paragraph (2)(C) and (D) of this subsection, no adjusted premium shall exceed 4% of the amount of insurance.

(4)(A) For a policy providing an amount of insurance varying with the duration of the policy, the equal uniform amount shall be the uniform amount of insurance provided by an otherwise similar policy that contained the same endowment benefits issued at the same age for the same term, with the benefits not varying with the duration of the policy and with the benefits valued the same on the date of issue as the benefits under the policy.

(B) For a policy providing a varying amount of insurance issued on the life of a child under age 10, the equal uniform amount may be computed as though the amount of insurance provided by the policy before the child became 10 was the amount of insurance provided at age 10.

(5)(A) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall equal the sum of the following:

(i) The adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits.

(ii) For the period when premiums for the term insurance benefits become payable, the adjusted premiums for the term insurance.

(B) Except as provided in subparagraph (C) of this paragraph, the equation in subparagraph (A) of this paragraph shall be calculated separately and according to paragraphs (1), (2), and (3) of this subsection.

(C) For paragraph (2)(B), (C), and (D) of this subsection, the amount of insurance or equal uniform amount of insurance used to calculate the adjusted premiums referred to in subparagraph (A)(ii) of this paragraph shall equal the excess of the corresponding amount determined for the entire policy over the amount used to calculate the adjusted premiums described in subparagraph (A)(i) of this paragraph.

(6)(A) Except as provided in subsections (d) and (e) of this section, paragraph (5)(B) and (C) of this subsection, and paragraph (8) of this subsection, all adjusted premiums and present values for ordinary insurance policies shall be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table.

(B) For ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age no more than 3 years younger than the actual age of the insured, and the calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table.

(C)(i) All calculations shall be made on the basis of the rate of interest, not exceeding 3 ½% per year, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

(ii) In calculating the present value of any paid-up term insurance with accompanying pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed shall not exceed 130% of the rates of mortality according to the applicable table.

(iii) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on another mortality table specified by the company and approved by the Commissioner.

(7)(A)(i) Except as provided in subparagraphs (B), (C), (D), and (E) of this paragraph and paragraph (8) of this subsection and for ordinary policies issued after the operative date of this paragraph, the adjusted premiums and present values shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the interest rate for calculating cash surrender values and paid-up nonforfeiture benefits shall be specified in the policy.

(ii) Except as provided in sub-subparagraph (iii) of this subparagraph, the interest rate shall not exceed 3 ½% per year.

(iii) An interest not exceeding 5 ½% per year may be used for policies issued after October 12, 1978.

(B) For ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age no more than 6 years younger than the actual age of the insured.

(C) In calculating the present value of a paid-up term insurance with pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed may be no more than the rates in the Commissioners 1958 Extended Term Insurance Table.

(D) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on another mortality table specified by the company and approved by the Commissioner.

(E)(i) After June 27, 1960, a company may file with the Commissioner a written notice of the company's election to comply with this paragraph after a specified date before January 1, 1966.

(ii) After filing the notice, then, on the specified date, this paragraph shall become operative for ordinary policies issued by the company.

(iii) If a company makes no election, then the operative date of the paragraph for the company shall be January 1, 1966.

(8)(A)(i) Except as provided in subparagraphs (B), (C), (D), and (E) of this paragraph and for industrial policies issued after the operative date of this paragraph, adjusted premiums and present values shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the interest rate for calculating cash surrender values and paid-up nonforfeiture benefits shall be specified in the policy.

(ii) Except as provided in subparagraph (A)(iii) of this paragraph, the interest rate shall not exceed 3 ½% per year.

(iii) An interest rate not exceeding 5 ½% per year may be used for policies issued after October 12, 1978.

(B) For individual insurance issued on female risks, adjusted premiums and present values may be calculated according to an age no more than 6 years younger than the actual age of the insured.

(C) In calculating the present value of any paid-up term insurance with pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed shall be no more than the rates in the Commissioners 1961 Industrial Extended Term Insurance Table.

(D) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on another mortality table specified by the company and approved by the Commissioner.

(E)(i) After October 3, 1962, a company may file with the Commissioner a written notice of the company's election to comply with this paragraph after a specified date before January 1, 1968.

(ii) After filing the notice, then, on the specified date, this paragraph shall become operative for the industrial policies issued by the company.

(iii) If a company makes no election, the operative date of this paragraph for the company shall be January 1, 1968.

(e)(1) This subsection shall apply to all policies issued after the operative date of this subsection.

(2) Except as provided in paragraph (7) of this subsection, the adjusted premiums for a policy shall be calculated on an annual basis and shall be the uniform percentage of the policy premiums for each policy year.

(3) The adjusted premium shall exclude amounts payable as extra premiums to cover impairments or special hazards and shall also exclude a uniform annual contract change or policy fee described in the policy statement of the method used to calculate the cash surrender values and paid-up nonforfeiture benefits.

(4) The present value, on the issuance date, of all adjusted premiums shall be equal to the sum of the following:

(A) The then present value of the future guaranteed benefits provided for by the policy.

(B) One per centum of either the amount of insurance for uniform amounts of insurance or the average amount of insurance at the beginning of each of the first 10 policy years.

(C) One hundred twenty-five per centum of the nonforfeiture net level premium.

(5) For the percentage described in paragraph (4)(C) of this subsection, no nonforfeiture net level premium shall be considered in excess of 4% of either

the amount of insurance for uniform amounts of insurance or the average amount of insurance at the beginning of each of the first 10 policy years.

(6) The policy shall issue when the rated age of the insured is determined.

(7) The nonforfeiture net level premium shall be equal to the present value, at the issuance date of the guaranteed benefits provided by the policy divided by the present value, on the issuance date, of an annuity of 1 per year payable when the policy issues and on each anniversary when a premium becomes due.

(8) For policies which create in a guaranteed basis unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present value shall initially be calculated on the assumption that future benefits and premiums do not change from benefits and premiums established when the policy issues.

(9) When the benefits or premiums change, the future adjusted premiums, the nonforfeiture net level, and the present values shall be recalculated on the assumption that future benefits and premiums do not change from the benefits and premiums established by the change.

(10) Except as provided by paragraph (15) of this subsection, the recalculated future adjusted premiums for the policy shall be the uniform percentage of the future premiums for each policy.

(11) The recalculated future premiums shall exclude amounts payable as extra premiums to cover impairments and special hazards and shall also exclude a uniform annual contract charge or policy fee described on the policy in a statement of the method used to calculate the cash surrender values and paid-up nonforfeiture benefits.

(12) At the time of the change to new benefits or premiums, the present value of all the future adjusted premiums shall equal the excess of the sum described in subparagraph (A) of this paragraph over the amount described in subparagraph (B) of this paragraph.

(A) The then present value of the future guaranteed benefits provided by the policy and the additional expense allowance.

(B) The then cash surrender value or present value of paid-up nonforfeiture benefit under the policy.

(13) At the time of the change to the new benefits or premiums, the additional expense allowance shall be the sum of the following:

(A) One per centum of the difference, if positive, between the average amount of insurance at the beginning of each of the first 10 policy years after the change and the average amount of insurance before the change at the beginning of each of the first 10 years after the most recent previous change or, if there has been no previous change, the issuance date.

(B) One hundred twenty-five per centum of the increase in the nonforfeiture net level premium.

(14) The recalculated nonforfeiture net level premium shall equal the result obtained by dividing the equation described in subparagraph (A) of this paragraph with the amount described in subparagraph (B) of this paragraph.

(A) This amount equals the sum of the following:

(i) The nonforfeiture net level premium before the change multiplied by the present value of an annuity of 1 per year payable, after the change, on each anniversary of the policy where a premium would have fallen due had the change not occurred.

(ii) The present value of the increase in future guaranteed benefits provided by the policy.

(B) This amount equals the present value of an annuity of 1 per year payable, after the change, on each anniversary of the policy where a premium falls due.

(15) For a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for the substandard policy may be calculated as if they were issued to provide the higher uniform amounts of insurance on the standard basis.

(16)(A)(i) Except as provided in subparagraphs (B) through (H) of this paragraph, adjusted premiums and present values shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1980 Standard Ordinary Mortality Table or, at the election of the company for any specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.

(ii) Adjusted premiums and present values shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table.

(iii) Adjusted premiums and present values shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate for policies issued in the calendar year.

(B) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of an interest rate not exceeding the nonforfeiture interest rate for policies issued in the immediately preceding calendar year.

(C) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available shall be calculated on the basis of the mortality table and the interest rate used to determine the amount of the paid-up nonforfeiture benefit and the paid-up dividend additions.

(D) A company may calculate the guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than the rate specified in the policy for calculating cash surrender values.

(E) In calculating the present value of a paid-up term insurance with pure endowment offered as a nonforfeiture benefit, the rates of mortality assumed shall be no more than the rates in the Commissioners 1980 Extended Term Insurance Table for ordinary insurance policies and no more than the Commissioners 1961 Industrial Extended Term Insurance Table for industrial insurance policies.

(F) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the tables described in subparagraph (E) of this paragraph.

(G) Any ordinary mortality tables adopted after 1980 by the National Association of Insurance Commissioners and by the Commissioner for determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table.

(H) Any industrial mortality tables adopted after 1980 by the National Association of Insurance Commissioners and approved by the Commissioner for determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

(17) The nonforfeiture interest rate for a policy issued in a particular calendar year shall be equal to 125% of the calendar year statutory valuation interest rate for the policy, as described in § 31-4701, rounded to the nearest $\frac{1}{4}\%$.

(18) Any refiling of nonforfeiture values or their methods of computation for a previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of other provisions of the policy form.

(19)(A) After March 14, 1985, a company may file with the Commissioner a written notice of the company's election to comply with this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for the category of insurance for the company.

(B) If a company makes no election for a category of insurance, the operative date for the category of insurance issued by the company shall be January 1, 1989.

(f) For life insurance with future premiums determined by the insurance company based on estimates of future experience or for life insurance with minimum values that cannot be determined according to subsections (a) through (e) of this section, the following requirements shall be complied with:

(1) The Commissioner shall be satisfied that the benefits are substantially as favorable to policyholders and insureds as the benefits required by subsections (a) through (e) of this section.

(2) The Commissioner shall be satisfied that the benefits and the pattern of premiums do not mislead prospective policyholders or insureds.

(3) The cash surrender values and paid-up nonforfeiture benefits shall not be less than the minimum values and benefits required by this section.

(g)(1) Any cash surrender value and any paid-up nonforfeiture benefit, available after a default in the payment of a premium due other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary.

(2) All values described in subsections (b) through (f) of this section may be calculated upon the assumption that any death benefit is payable at the end of the policy or contract year of death.

(3) Besides paid-up term additions, the net value of paid-up additions shall be at least the amounts used to provide the additions.

(4)(A) Notwithstanding subsection (b) of this section, additional benefits payable under the following conditions shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits under this section:

- (i) For death or dismemberment by accident.
- (ii) For total and permanent disability.
- (iii) Reversionary annuity or deferred reversionary annuity benefits.
- (iv) Term insurance benefits provided by a rider or by a supplementary policy provision which if issued as a separate policy would not be under this section.

(v) Term insurance on the lives of children under a policy on the life of a parent of the children if the term insurance expires before a child's age is 26, if the term insurance is uniform in amount after a child's age is 1, and if the term insurance has not been paid up because of the parent's death.

(vi) Other policy benefits in addition to life insurance, endowment benefits, and premiums for the additional benefits.

(B) No additional benefits described in paragraph (4)(A) of this subsection shall be required in paid-up nonforfeiture benefits.

(h)(1) This subsection shall apply to policies issued after December 31, 1986.

(2) For uniform amounts of insurance, a cash surrender value available after a default on a premium due on a policy anniversary shall not differ by more than $\frac{1}{5}$ of 1% of the amount of insurance from the sum of the following:

(A) Either zero or the basic cash value, whichever is greater.

(B) The present value of existing paid-up additions exceeding policy indebtedness to the company.

(3) For insurance amounts not treated in paragraph (2) of this subsection, a cash surrender value available after a default on a premium due on a policy anniversary shall not differ by more than $\frac{1}{5}$ of 1% of the average insurance amounts at the beginning of the first 10 policy years from the sum of the following:

(A) Either zero or the basic cash value, whichever is greater.

(B) The present value of existing paid-up additions exceeding policy indebtedness to the company.

(4)(A) Except as provided in subparagraphs (B) and (C) of this paragraph, the basic cash value shall equal the present value at the policy anniversary of the future guaranteed benefits exceeding the present value on nonforfeiture factors corresponding with premiums due after the eve of the anniversary.

(B) The future guaranteed benefits used to determine the basic cash value excludes existing paid-up additions and, where there has been no default in premium payments, would be computed without deducting indebtedness to the company.

(C) The basic cash value for supplemental life insurance, annuity benefits, or family coverage shall not be affected differently than cash surrender values described in subsections (b) and (d) of this section.

(5)(A) The nonforfeiture factor for a policy year shall be a percentage of the adjusted premium for the policy year.

(B) Except as provided in paragraph (6) of this subsection, the adjusted premium percentage shall comply with the following:

(i) Except as provided in subparagraph (B)(ii) of this paragraph, the percentage cannot change during policy years between the 2nd policy anniversary and the 5th policy anniversary.

(ii) Unless the 5th anniversary precedes an anniversary when a cash surrender value without paid-up additions and without indebtedness deductions equal at least $\frac{1}{5}$ of 1% of the amount described in subparagraph (iii) of this paragraph, the percentage cannot change during policy years between the 2nd anniversary and an anniversary with a cash surrender value, without the additions and the deductions, equaling at least $\frac{1}{5}$ of 1% of the subparagraph (iii) amount.

(iii) The average amount of insurance at the beginning of the first 10 policy years.

(iv) After the latest anniversary referred to in subparagraph (B)(ii) of this paragraph, or the 5th policy anniversary if later, no percentage may apply to fewer than 5 consecutive policy years.

(6) The basic cash value shall exceed the amount that would result in the paragraph (4) formula by replacing the nonforfeiture factors with adjusted premiums.

(7)(A) Adjusted premiums and present values shall be calculated on the mortality and interest rate bases permitted by the Life Insurance Amendments Reform Act of 1984.

(B) The cash surrender values all include endowment benefits under the policy.

(8)(A) Except for a defaulted premium due on a policy anniversary, a cash surrender value and a paid-up nonforfeiture benefit arising from a premium default shall be determined consistently with subsections (a) through (g) of this section.

(B) The cash surrender values and the paid up nonforfeiture benefits granted with additional benefits shall conform with this subsection.

(i)(1) After February 19, 1948, a company, in writing, may inform the Commissioner of the company's election to comply with this section after an expressly selected date before January 1, 1950.

(2) After filing the notice described in paragraph (1) of this subsection, this section shall govern the policies and the contracts issued by the company after the date.

(3) Except as provided in paragraph (4) of this subsection and if a company does not choose a date, then, beginning January 1, 1950, this section shall govern the company.

(4) Subsection (d)(6) and (7) of this section and subsection (e) of this section expressly establish dates when those provisions govern a company.

(j)(1) This section shall not apply to the following:

(A) Reinsurance.

(B) Group insurance.

(C) Pure endowment.

(D) Annuity or reversionary annuity contract.

(E) Uniform amounts of term policy, with no guaranteed nonforfeiture or endowment benefits and with no renewal of guaranteed nonforfeiture or endowment benefits, for a term that lasts no more than 20 years and that expires before the insured becomes age 71, and with premiums payable throughout the policy term.

(F) Decreasing amounts of term policy with no guaranteed nonforfeiture or endowment benefits, with adjusted premiums under subsections (d) and (e) of this section exceeded by adjusted premiums for uniform amounts of term policy, for a term that lasts no more than 20 years and that expires before the insured becomes age 71, and for a policy issued at the same age and for the same initial amount of insurance as originally provided by the policy.

(G) A policy with guaranteed nonforfeiture or endowment benefits with no cash value or present value of a paid-up nonforfeiture benefit at the beginning of a policy year exceeding 2 ½% of the amount of insurance at the beginning of the policy year.

(H) A policy delivered outside the District of Columbia by an agent of the company.

(2) For this section, the expiration age for joint term life insurance shall be the age of the oldest life when the insurance expires.

(June 19, 1934, ch. 672, ch. V, § 5b; Feb. 19, 1948, 62 Stat. 30, ch. 66, § 4; June 27, 1960, 74 Stat. 228, Pub. L. 86-530, § 2; Oct. 3, 1962, 76 Stat. 712, Pub. L. 87-738, § 2; Oct. 13, 1978, D.C. Law 2-120, §§ 6 to 8, 25 DCR 1519; Mar. 14, 1985, D.C. Law 5-160, § 3(f), 32 DCR 39; Feb. 24, 1987, D.C. Law 6-192, § 25(e)-(g), 33 DCR 7836; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(a), 45 DCR 745.)

Section references. — This section is referred to in §§ 31-4701, 31-4703, 31-4705.01, 31-4705.04, and 31-4722.

Prior Codifications. — 1981 Ed., § 35-507. 1973 Ed., § 35-705b.

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Legislative history of Law 6-192. — For legislative history of D.C. Law 6-192, see Historical and Statutory Notes following § 31-4703.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-4701.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

References in text. — “The Life Insurance Amendments Reform Act of 1984,” referred to in subparagraph (A) of paragraph (7) of subsection (h), is D.C. Law 5-160, codified primarily within Chapters 43, 44, and 47 of Title 31.

§ 31-4705.03. Standard nonforfeiture law — Individual deferred annuities.

(a) This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship)

or by an employee organization, or by both, other than a plan providing individual retirement accounts of individual retirement annuities under § 408 of the Internal Revenue Code of 1954 (88 Stat. 959; § 408 of Title 26, United States Code), as now or hereafter amended, premium deposit fund, variable contract, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside the District of Columbia through an agent or other representative of the company issuing the contract.

(b)(1) In the case of contracts issued on or after the operative date of this section as defined in subsection (k) of this section, no contract of annuity, except as stated in subsection (a) of this section, shall be delivered or issued for delivery in the District of Columbia unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the contract holder:

(A) That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (d), (e), (f), (g), and (i) of this section;

(B) If a contract provides for a lump-sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit as cash surrender benefit of such amount as is specified in subsections (d), (e), (g), and (i) of this section. The company shall reserve the right to defer the payment of such cash surrender benefit for a period of 6 months after demand therefor with surrender of the contract;

(C) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits; and

(D) A brief and general statement of the method to be used in calculating any paid-up annuity, cash surrender or death benefits that may be available under the contract and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

(2) Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than \$20 monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(c) The minimum values as specified in subsections (d), (e), (f), (g), and (i) of this section of any paid-up annuity, cash surrender or death benefits available

under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subsection:

(1)(A) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of 1.5% per year of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrender of the contract accumulated at a rate of interest of 1.5% per year; and

(ii) The amount of any indebtedness to the company on the contract, including interest due and accrued; and increased by any existing additional amounts credited by the company to the contract;

(A-i) Notwithstanding the interest rate of 1.5% per year used to calculate the minimum nonforfeiture amount under subparagraph (A) of this paragraph, the Mayor shall issue regulations which shall set forth the computation of the interest rate used to determine the minimum nonforfeiture amount. The regulations shall apply to any contract issued on or after the effective date of the regulations.

(B) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than 0 and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of \$30 and less a collection charge of \$1.25 per consideration credited to the contract during that contract year. The percentages of net considerations shall be 65% of the net consideration for the 1st contract year and 87 ½% of the net considerations for the 2nd and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be 65% of the portion of the total net consideration for any renewal contract year which exceeds by not more than 2 times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%;

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with 2 exceptions:

(A) The portion of the net consideration for the 1st contract year to be accumulated shall be the sum of 65% of the net consideration for the 1st contract year plus 22 ½% of the excess of the net consideration for the 1st contract year over the lesser of the net considerations for the 2nd and 3rd contract years; and

(B) The annual contract charge shall be the lesser of \$30 or 10% of the gross annual consideration;

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90% and the net consideration shall be the gross consideration less a contract charge of \$75.

(d) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(e) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than 1 percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(f) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of the paid-up annuity benefit be less than the minimum nonforfeiture amount at the time.

(g) For the purpose of determining the benefits calculated under subsections (e) and (f) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

(h) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(i) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(j) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (d), (e), (f), (g), and (i) of this section, additional benefits payable: (1) in the event of total and permanent disability; (2) as reversionary annuity or deferred reversionary annuity benefits; or (3) as other policy benefits additional to life insurance, endowment and annuity benefits; and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

(k) After October 13, 1978, any company may file with the Commissioner a written notice of its election to comply with the provisions of this section after a specified date which is no more than 2 years after such effective date. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be 2 years after October 13, 1978.

(June 19, 1934, ch. 672, ch. V, § 5c as added Oct. 13, 1978, D.C. Law 2-120, § 9(b), 25 DCR 1519; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(b), 45 DCR 745; Feb. 6, 2004, D.C. Law 15-63, § 2, 50 DCR 9301; Apr. 13, 2005, D.C. Law 15-354, § 48, 52 DCR 2638; Mar. 2, 2007, D.C. Law 16-191, § 48(c), 53 DCR 6794.)

Section references. — This section is referred to in § 31-4705.

Prior Codifications. — 1981 Ed., § 35-508. 1973 Ed., § 35-705c.

Effect of amendments. — D.C. Law 15-63, in subsec. (c)(1), substituted “1.5% per year” for “3% per annum” throughout subpar. (A), and added subpar. (A-1).

D.C. Law 15-354, in subsec. (c)(1)(A)(A-i), substituted “(A-I) Notwithstanding” for “(A-1) Notwithstanding”.

D.C. Law 16-191, in subsec. (c)(1)(A-i), validated a previously made technical correction.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Standard Valuation and Nonforfeiture Temporary Amendment Act of 2002 (D.C. Law 14-278, April 2, 2003, law notification 50 DCR 3377).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Standard Valuation and Nonforfeiture Emer-

agency Amendment Act of 2002 (D.C. Act 14-565, December 23, 2002, 50 DCR 287).

For temporary (90 day) amendment of section, see § 2 of Standard Valuation and Nonforfeiture Congressional Review Emergency Amendment Act of 2003 (D.C. Act 15-37, March 24, 2003, 50 DCR 2772).

For temporary (90 day) amendment of section, see § 2 of Standard Valuation and Nonforfeiture Emergency Amendment Act of 2003 (D.C. Act 15-204, October 24, 2003, 50 DCR 9842).

For temporary (90 day) amendment of section, see § 2 of Standard Valuation Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-355, February 19, 2004, 51 DCR 2322).

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4705.02.

Legislative history of Law 15-63. — Law 15-63, the “Standard Valuation and Nonforfeiture Amendment Act of 2003”, was introduced in Council and assigned Bill No. 15-17, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on July 8, 2003, and October 7, 2003, respectively. Signed by the Mayor on October 24, 2003, it was assigned Act No. 15-181 and transmitted to both Houses of Congress for its review. D.C. Law 15-63 became effective on February 6, 2004.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 16-191. — For Law 16-191, see notes following § 31-1131.02.

References in text. — Section 408 of the Internal Revenue Code of 1954, referred to in subsection (a) has been retained under the Internal Revenue Code of 1986.

§ 31-4705.04. Loan provisions in policies.

(a) In the case of ordinary policies issued prior to the operative date of § 31-4705.02 (the standard nonforfeiture law) the loan value referred to in paragraph (6) of subsection (a) of § 31-4703 shall be the reserve at the end of the current policy year on the policy and on the dividend additions thereto, if any, exclusive of the reserve on account of return premium insurance and of total and permanent disability and additional accidental death benefits, less a sum not more than 2 ½% of the amount insured by the policy and of any dividend additions thereto (the policy to specify the mortality table and rate of interest adopted for computing such reserve). The policy may provide that such loan may be deferred for not exceeding 6 months after the application therefor is made. A company may, in lieu of the provision hereinabove permitted for the deduction from a loan on the policy of a sum not more than 2 ½% of the amount insured by the policy and of any dividend additions thereto, insert in the policy a provision that one fifth of the said reserve may be deducted in case of a loan under the policy, or may provide therein that the deduction may be the said 2 ½% or the one fifth of the said reserve at the option of the company.

(b) In the case of ordinary policies issued on or after the operative date of § 31-4705.02 (the standard nonforfeiture law) the loan value referred to in paragraph (6) of subsection (a) of § 31-4703 shall be the cash surrender value at the end of the current policy year as required by § 31-4705.02. The company shall reserve the right to defer such loan, except when made to pay premiums, for 6 months after application therefor is made.

(June 19, 1934, ch. 672, ch. V, § 5c; Feb. 19, 1948, 62 Stat. 30, ch. 66, § 4; redesignated § 5d Oct. 13, 1978, D.C. Law 2-120, § 9, 25 DCR 1519.)

Section references. — This section is referred to in § 31-4703.

Prior Codifications. — 1981 Ed., § 35-509. 1973 Ed., § 35-705d.

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see Historical and Statutory Notes following § 31-4701.

References in text. — The “operative date

of § 31-4705.02,” referred to in subsections (a) and (b) of this section, was prescribed by § 2 of the Act of October 13, 1962, 76 Stat. 712, Pub. L. 87-738, which was formerly codified as § 35-507(g) (1981 Ed.). Section 35-507 § 31-4705.02, 2001 Ed. was rewritten effective March 14, 1985, and no longer contains the “operative date” language.

§ 31-4706. Extension of time for payment of premiums.

A life company may enter into subsequent agreements in writing with the insured, which need not be attached to the policy, to extend the time for the payment of any premium, or part thereof, upon condition that failure to comply with the terms of such agreement shall lapse the policy, as provided in said agreement or in the policy. Subject to such lien as may be created to secure any indebtedness contracted by the insured, in consideration of such extension, said agreement shall not impair any right existing under the policy.

(June 19, 1934, 48 Stat. 1164, ch. 672, ch. V, § 6.)

Prior Codifications. — 1981 Ed., § 35-510. 1973 Ed., § 35-706.

§ 31-4707. Ascertainment of loan indebtedness.

In ascertaining the indebtedness due upon policy or premium loans the interest, if not paid when due, shall be added to the principal of such loans and shall bear interest at the rate specified in the note or loan agreement.

(June 19, 1934, 48 Stat. 1164, ch. 672, ch. V, § 7.)

Prior Codifications. — 1981 Ed., § 35-511. 1973 Ed., § 35-707.

§ 31-4708. Filing and approval of life policy forms.

A policy of life insurance shall not be issued or delivered in the District until the form of the same has been filed with the Commissioner, nor if the Commissioner gives written notice, within 30 days of such filing, to the company proposing to issue it, showing wherein the form of such policy does not comply with the requirements of the laws of the District, provided that such action of the Commissioner shall be subject to review by a court of competent jurisdiction.

(June 19, 1934, 48 Stat. 1164, ch. 672, ch. V, § 8; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(c), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-512. 1973 Ed., § 35-708.

Legislative history of Law 12-81. — For

legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4705.02.

§ 31-4709. Policy provisions required by foreign government entities.

The policies of a life company, not organized under the laws of the District, may contain any provisions prescribed by the laws of the state, territory, district, or country, under which the company is organized. The policies of a life company, organized under the laws of the District, may, when issued or delivered in any state, territory, district, or country, contain any provisions required by the laws of the state, territory, district, or country in which the same are issued or delivered, anything in this subdivision to the contrary notwithstanding.

(June 14, 1934, 48 Stat. 1164, ch. 672, ch. V, § 9.)

Prior Codifications. — 1981 Ed., § 35-513. 1973 Ed., § 35-709.

§ 31-4710. Group policies — General requirements. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1164, ch. 672, ch. V, § 10; July 2, 1940, 54 Stat. 726, ch. 518; July 12, 1950, 64 Stat. 330, ch. 457, § 1; July 5, 1960, 74 Stat. 315, 316, Pub. L. 86-579, §§ 1-5; Sept. 14, 1961, 75 Stat. 519, Pub. L. 87-249, § 1; Oct. 23, 1962, 76 Stat. 1131, Pub. L. 87-855, §§ 1, 2; Sept. 20, 1966, 80 Stat. 821, Pub. L. 89-594, § 1; Aug. 14, 1973, 87 Stat. 304, Pub. L. 93-89, title III, § 301; Feb. 23, 1980, D.C. Law 3-52, § 3, 27 DCR 26; Dec. 10, 1981, D.C. Law 4-55, § 2, 28 DCR 4649; May 10, 1989, D.C. Law 7-231, § 43, 36 DCR 492; Feb. 5, 1994, D.C. Law 10-68, § 31, 40 DCR 6311; Nov. 13, 2003, D.C. Law 15-39, § 2302(a), 50 DCR 5668.)

Prior Codifications. — 1981 Ed., § 35-514. 1973 Ed., § 35-710.

Effect of amendments. — D.C. Law 15-39 repealed this section.

Emergency legislation. — For temporary (90 day) repeal of section, see § 2202(a) of Fiscal Year 2004 Budget Support Emergency Act of 2003 (D.C. Act 15-105, June 20, 2003, 50 DCR 5613).

For temporary (90 day) repeal of section, see § 2202(a) of Fiscal Year 2004 Budget Support Congressional Review Emergency Act of 2003 (D.C. Act 15-149, September 22, 2003, 50 DCR 8360).

Legislative history of Law 3-52. — Law 3-52, the “District of Columbia Insurance Act Amendments of 1979,” was introduced in Council and assigned Bill No. 3-53, which was referred to the Committee on Public Services and Consumer Affairs. The Bill was adopted on first and second readings on November 20, 1979, and December 4, 1979, respectively. Signed by the Mayor on December 21, 1979, it was as-

signed Act No. 3-142 and transmitted to both Houses of Congress for its review.

Legislative history of Law 4-55. — Law 4-55, the “Credit Union Life Insurance Ceiling Amendment Act of 1981,” was introduced in Council and assigned Bill No. 4-291, which was referred to the Committee on Finance and Revenue. The Bill was adopted on first and second readings on September 15, 1981, and September 29, 1981, respectively. Signed by the Mayor on October 19, 1981, it was assigned Act No. 4-96 and transmitted to both Houses of Congress for its review.

Legislative history of Law 7-231. — Law 7-231, the “Technical Amendments Act of 1988,” was introduced in Council and assigned Bill No. 7-586, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 29, 1988 and December 13, 1988, respectively. Signed by the Mayor on January 6, 1989, it was assigned Act No. 7-285 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-68. — Law 10-68, the “Technical Amendments Act of 1993,” was introduced in Council and assigned Bill No. 10-166, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 23, 1993, it was assigned Act No. 10-107 and transmitted to both Houses of Congress for its review. D.C. Law 10-68 became effective on February 5, 1994.

Legislative history of Law 15-39. — Law 15-39, the “Fiscal Year 2004 Budget Support Act of 2003,” was introduced in Council and assigned Bill No. 15-218, which was referred to Committee on Whole. The Bill was adopted on first and second readings on May 6, 2003, and June 3, 2003, respectively. Signed by the Mayor on June 20, 2003, it was assigned Act No. 15-106 and transmitted to both Houses of Congress for its review. D.C. Law 15-39 became effective on November 13, 2003.

Short title. — Short title of title XXIII of Law 15-39: Section 2301 of D.C. Law 15-39

provided that title XXIII of the act may be cited as the Life Insurance Amendment Act of 2003.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-4711. Group policies — Required provisions.

No policy of group life insurance shall be delivered in the District unless it contains in substance the following provisions, or provisions which in the opinion of the Commissioner are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; provided, however: (1) that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; (2) that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies; and (3) that subject to the terms of the policy any person insured under a group life insurance contract, whether issued before or after August 14, 1973, may make to any person, other than his employer, an absolute or collateral assignment of any or all the rights and benefits conferred on him by any provision of such policy or by law, including specifically, but not by way of limitation, any right to designate a beneficiary or beneficiaries thereunder and any right to have an individual policy issued upon termination either of employment or of said policy of group life insurance; but nothing herein shall be construed to have prohibited an insured from making an assignment of all or any part of his rights and privileges under the policy before August 14, 1973, and, subject to the terms of the policy, an assignment by an insured before or after August 14, 1973, is valid for the purposes of vesting in the assignee all rights and privileges so assigned, but without prejudice to the insurer on account of any

payment it may make or individual policy it may issue prior to receipt of notice of the assignment:

(1) A provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by him;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage;

(5) A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(6) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary as to all or any part of such sum living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding \$250 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured;

(7) A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs (8), (9), and (10) of this section;

(8) A provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of

membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the 1st premium paid to the insurer, within 31 days after such termination: And provided further, that:

(A) The individual policy shall, at the option of such person, be on any 1 of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(B) The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in 1 sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(C) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his age attained on the effective date of the individual policy;

(9) A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least 5 years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph (8) of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(A) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after such termination; and

(B) \$2,000; and

(10) A provision that if a person insured under the group policy dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with subparagraph (8) or (9) of this section and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the 1st premium therefor has been made.

(June 19, 1934, 48 Stat. 1165, ch. 672, ch. V, § 11; July 2, 1940, 54 Stat. 726, ch. 518; July 12, 1950, 64 Stat. 333, ch. 457, § 2; Oct. 3, 1962, 76 Stat. 715, Pub. L. 87-740, § 1; Aug. 14, 1973, 87 Stat. 304, Pub. L. 93-89, title III, § 302; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730; Nov. 13, 2003, D.C. Law 15-39, § 2302(b), 50 DCR 5668.)

Cross references. — Copy of application, required delivery with policy, see § 31-5203.

False statements in application, effect, see § 31-4314.

Prior Codifications. — 1981 Ed., § 35-515. 1973 Ed., § 35-711.

Effect of amendments. — D.C. Law 15-39, in the introductory paragraph, substituted “(1) that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; (2) that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies; and (3)” for “(1) that subparagraphs (6) to (10) of this section, inclusive, shall not apply to policies issued to a creditor to insure debtors of such creditor, or to policies issued pursuant to paragraph (8) of § 31-4710; (2) that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; (3) that if

the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies; and (4)”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 2202(b) of Fiscal Year 2004 Budget Support Emergency Act of 2003 (D.C. Act 15-105, June 20, 2003, 50 DCR 5613).

For temporary (90 day) amendment of section, see § 2202(b) of Fiscal Year 2004 Budget Support Congressional Review Emergency Act of 2003 (D.C. Act 15-149, September 22, 2003, 50 DCR 8360).

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 15-39. — For Law 15-39, see notes following § 31-4710.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4711.01. Group policies — Right to, and notice of, issuance of individual policy.

(a) If any individual insured under a group life insurance policy hereafter delivered in the District becomes entitled under the terms of such policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to making of application and payment of the 1st premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least 15 days prior to the expiration date of such period, then, in such event, the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire 15 days next after the individual is given such notice but in no event shall such additional period extend beyond 60 days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this subsection.

(b) Except as provided in this chapter it shall be unlawful to make a contract of life insurance for a group in the District.

(June 19, 1934, ch. 672, ch. V, § 11(a), as added July 12, 1950, 64 Stat. 333, ch. 457, § 2.)

Prior Codifications. — 1981 Ed., § 35-516. 1973 Ed., § 35-711a.

§ 31-4712. Accident and sickness policies.

(a) *Filing requirements.* — No policy of insurance against loss resulting from sickness or from bodily injury or death by accident, or both, shall be issued or delivered to any person in the District by any company organized under this or any other law of the District, or, if a foreign or alien company, authorized to do business in the District, including, but not limited to, all Health Maintenance Organizations, Group Hospitalization and Medical Services, Inc., all life insurance companies licensed to do business in the District, and all for-profit as well as nonprofit health insurers issuing or delivering expense incurred accident and sickness health insurance policies and certificates, until a copy of the form thereof, and of the classification of risks and the premium rates appertaining thereto, have been filed with the Commissioner; nor shall it be so issued or delivered until the expiration of 30 days after it has been so filed, unless the Commissioner shall sooner give his written approval thereto. If the Commissioner shall give written notice to the company which has filed such form that it does not comply with the requirements of law, specifying the reasons for his opinion, it shall be unlawful thereafter for any such insurer to issue any policy in such form. Rates filed with respect to a policy or certificate subject to the Reasonable Health Insurance Ratemaking Reform Act of 2010 [Chapters 30A, 31C, and 33A of this title] shall also comply with the provisions of such act.

(b) *Form.* —

(1) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in the District unless:

(A) The entire money and other considerations therefor are expressed therein;

(B) The time at which the insurance takes effect and terminates is expressed therein;

(C) It purports to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any 2 or more eligible members of that family, including spouse, domestic partner, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder;

(D) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lowercase unspaced alphabet length not less than 120-point (the text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(E) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in subsection (c) of this section, are printed, at the insurer's option, either included with the benefit provision to

which they apply, or under an appropriate caption such as "EXCEPTIONS," or "EXCEPTIONS AND REDUCTIONS"; provided, that, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(F) Each such form, including riders and endorsements, shall be identified by a former number in the lower left-hand corner of the 1st page thereof;

(G) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Commissioner;

(H) It contains no provision which would restrict access to psychologists or optometrists. When a policy relating to health insurance requires payment or reimbursement for services which may be performed by a duly licensed psychologist or optometrist, any person covered by the policy shall be free to select and have direct access to such psychologist or optometrist without supervision or referral by a practitioner of the healing art and shall be entitled, under the policy, to have payment or reimbursement made for services performed;

(I) For a policy issued or renewed after April 15, 1995, it contains a provision covering a minor grandchild, niece, or nephew of an employee of the District of Columbia if the minor grandchild, niece, or nephew is under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session; and

(J) For a policy issued or renewed after April 15, 1996, it contains a provision covering a minor grandchild, niece, or nephew under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

(2) If any policy is issued by an insurer domiciled in the District for delivery to a person residing in another jurisdiction, and if the official having responsibility for the administration of the insurance laws of such other jurisdiction shall have advised the Commissioner that any such policy is not subject to approval or disapproval by such official, the Commissioner may by ruling require that such policy meet the standards set forth in paragraph (1) of this subsection and in subsection (c) of this section.

(c) *Provisions.* —

(1) *Required provisions.* — Except as provided in paragraph (3) of this subsection each such policy delivered or issued for delivery to any person in the

District shall contain the provisions specified in this paragraph in the words in which the same appear in this paragraph; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this paragraph or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve:

(A) A provision as follows:

“ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.”

(B)(i) A provision as follows:

“TIME LIMIT ON CERTAIN DEFENSES: After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 3-year period.”

(ii) (The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of subparagraphs (A), (B), (C), (D), and (E) of paragraph (2) of this subsection in the event of misstatement with respect to age or occupation or other insurance.)

(iii) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue; may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer’s option) under the caption “INCONTESTABLE.”

“After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured has a disability), it shall become incontestable as to the statements contained in the application.”

“No claim for loss incurred or disability (as defined in the policy) commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.”

(C)(i) A provision as follows:

“GRACE PERIOD: A grace period of (insert a number not less than ‘7’ for weekly premium policies, ‘10’ for monthly premium policies, and ‘31’ for all other policies) days will be granted for the payment of each premium falling due after the 1st premium, during which grace period the policy shall continue in force.”

(ii) A policy which contains a cancellation provision may add, at the end of the above provision, "Subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

(iii) A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision;

"Unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

(D)(i) A provision as follows:

"REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(ii) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue.

(E)(i) A provision as follows:

"NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

(ii) In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the 1st and 2nd sentences of the above provision:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of

claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.”.

(F) A provision as follows:

“CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.”

(G) A provision as follows:

“PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.”.

(H) A provision as follows:

“TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.”.

(I)(i) A provision as follows:

“PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.”.

(ii) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity up to an amount not exceeding \$. (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage or domestic partnership of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

"Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

(J) A provision as follows:

"PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

(K) A provision as follows:

"LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished."

(L)(i) A provision as follows:

"CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."

(ii) The 1st clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(2) *Other provisions.* — Except as provided in paragraph (3) of this subsection, no such policy delivered or issued for delivery to any person in the District shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this paragraph; provided, however, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this paragraph or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve:

(A) A provision as follows:

“CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess prorata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the official having supervision of insurance in the jurisdiction where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such jurisdiction prior to the occurrence of the loss or prior to the date of proof of change in occupation.”.

(B) A provision as follows:

“MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.”.

(C)(i) A provision as follows:

“OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for (insert type of coverage or coverages) in excess of \$. (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.”.

(ii) Or, in lieu thereof: “Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.”.

(D)(i) A provision as follows:

“INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had

notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(ii) If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "—EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no 3rd party liability coverage shall be included as "other valid coverage."

(E)(i) A provision as follows:

"INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(ii) If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "—OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, or

benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no 3rd-party liability coverage shall be included as "other valid coverage."

(F)(i) A provision as follows:

"RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of \$200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

(ii) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss-of-time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other jurisdiction of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations;

(G) A provision as follows:

"UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."

(H) A provision as follows:

"CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown

by the records of the insurer, stating when, not less than 5 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the official having supervision of insurance in the jurisdiction where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.”.

(I) A provision as follows:

“CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the jurisdiction in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.”.

(J) A provision as follows:

“ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured’s commission of or attempt to commit a felony or to which a contributing cause was the insured’s being engaged in an illegal occupation.”.

(K) Repealed.

(3) *Inapplicable or inconsistent provisions.* — If any provision of this subsection is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) *Order.* — The provisions which are the subject of paragraphs (1) and (2) of this subsection, or any corresponding provisions which are used in lieu thereof in accordance with such paragraphs, shall be printed in the consecutive order of the provisions in such paragraphs or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(5) *Third-party rights.* — The word “insured,” as used in this section, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(6) *Rules and regulations.* — The Council of the District of Columbia may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this section as are necessary, proper or advisable to the administration of this section. This provision shall not abridge any other authority granted the Commissioner by law.

(d) *Conforming to statutory requirements.* —

(1) *Provisions not subject to requirements.* — No policy provision which is not subject to subsection (c) of this section shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this section.

(2) *Violations and conflicts.* — A policy delivered or issued for delivery to any person in the District in violation of this section shall be held valid but shall be construed as provided in this section. When any provision in a policy subject to this section is in conflict with any provision of this section, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of this section.

(e) *Applications.* —

(1) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in the District shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(2) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) The falsity of any statement in the application for any policy covered by this section may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(f) *Waiver of insurer's rights.* — The acknowledgment by any insurer of the receipt of notice given under any policy covered by this section, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(g) *Limitations on coverage.* — If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased

prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

(h) *Exceptions.* — Except as provided in § 31-4724, nothing in this section shall apply to or affect:

(1) Repealed.

(2) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as:

(A) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(B) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall come to have a total and permanent disability, as defined by the contract or supplemental contract; provided, that no such supplemental contract shall be issued or delivered to any person in the District unless and until a copy of the form thereof has been submitted to and approved by the Commissioner under such reasonable rules and regulations as the Council of the District of Columbia shall make concerning the provisions in such contracts and their submission to and approval by him.

(June 19, 1934, 48 Stat. 1166, ch. 672, ch. V, § 12; July 12, 1950, 64 Stat. 335, ch. 457, § 3; July 16, 1953, 67 Stat. 162, ch. 196, § 1; Feb. 19, 1976, D.C. Law 1-46, § 2, 22 DCR 4680; Feb. 11, 1982, D.C. Law 4-66, § 2(a), 28 DCR 5040; Aug. 25, 1994, D.C. Law 10-158, § 2, 41 DCR 4881; Apr. 18, 1996, D.C. Law 11-110, § 36, 43 DCR 530; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(d), 45 DCR 745; Mar. 8, 2007, D.C. Law 16-247, § 2, 54 DCR 620; Apr. 24, 2007, D.C. Law 16-305, § 43, 53 DCR 6198; Sept. 12, 2008, D.C. Law 17-231, § 28(c), 55 DCR 6758; Mar. 25, 2009, D.C. Law 17-353, § 199, 56 DCR 1117; Apr. 8, 2011, D.C. Law 18-360, § 504, 58 DCR 896.)

Cross references. — Health and accident companies, see § 31-5202.

Health and accident policies issued by companies operating under Fire and Casualty Act, see § 31-2502.28.

Prior Codifications. — 1981 Ed., § 35-517. 1973 Ed., § 35-712.

Effect of amendments. — D.C. Law 16-247 repealed subsec. (c)(2)(K) which had read as follows: “(K) A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.”

D.C. Law 16-305, in subsec. (c)(1)(B)(iii), substituted “has a disability” for “is disabled”; and in subsec. (h)(2)(B), substituted “have a total

and permanent disability” for “become totally and permanently disabled”.

D.C. Law 17-231, in subsecs. (b)(1)(C), substituted “spouse; domestic partner” for “husband, wife”; and, in subsec. (c)(1)(I)(ii), substituted “marriage or domestic partnership” for “marriage”.

D.C. Law 17-353, in subsec. (h)(2)(B), substituted “come to have a total” for “have a total”.

D.C. Law 18-360, in subsec. (a), rewrote the last sentence which had read as follows: “The action of the Commissioner in this regard shall be subject to appeal and review in the form and manner prescribed in § 31-4327.”; and repealed subsec. (h)(1), which formerly read:

“(1) Any policy of group accident, group health, or group accident and health insurance; or”

Legislative history of Law 1-46. — Law 1-46, the “Access to Psychologists and Optometrists Act,” was introduced in Council and

assigned Bill No. 1-86, which was referred to the Committee on Human Resources and Aging. The Bill was adopted on first and second readings on October 7, 1975, and October 21, 1975, respectively. Signed by the Mayor on November 7, 1975, it was assigned Act No. 1-64 and transmitted to both Houses of Congress for its review.

Legislative history of Law 4-66. — Law 4-66, the "Access to Clinical Psychologists and Optometrists Act of 1981," was introduced in Council and assigned Bill No. 4-160, which was referred to the Committee on Housing and Economic Development. The Bill was adopted on first and second readings on October 13, 1981, and October 27, 1981, respectively. Signed by the Mayor on November 9, 1981, it was assigned Act No. 4-112 and transmitted to both Houses of Congress for its review.

Legislative history of Law 10-158. — Law 10-158, the "Primary Caretaker Insurance Coverage for Minors Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-112, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 7, 1994, and June 21, 1994, respectively. Signed by the Mayor on July 8, 1994, it was assigned Act No. 10-274 and transmitted to both Houses of Congress for its review. D.C. Law 10-158 became effective on August 25, 1994.

Legislative history of Law 11-110. — Law 11-110, the "Technical Amendments Act of 1996," was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 26, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-4705.02.

Legislative history of Law 16-247. — For Law 16-247, see notes following § 31-3103.

Legislative history of Law 16-305. — For Law 16-305, see notes following § 31-1131.11.

Legislative history of Law 17-231. — For Law 17-231, see notes following § 31-3301.01.

Legislative history of Law 17-353. — For Law 17-353, see notes following § 31-1131.06.

Legislative history of Law 18-360. — For history of Law 18-360, see notes under § 31-2231.11.

References in text. — Section 31-4327, referred to in subsection (a) of this section, was repealed by D.C. Law 11-227, § 16, effective April 9, 1997.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

Section 4 of D.C. Law 16-247 provided: "This act shall apply to all individual and group health benefit plans delivered, issued for delivery, or renewed on the first day of the month beginning on or after 90 days after the effective date of this act."

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 402(276) of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to the District of Columbia Council, subject to the right of the Commissioner as provided in § 406 of the Plan. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Applications.

Burden of proof.

Construction and application.

Review.

Applications.

An insured's failure to state, in hospitaliza-

tion policy application inquiring as to past medical or surgical treatment, that her cervix had been cauterized, precluded recovery of hospitalization benefits under policy, where failure to disclose such fact was intended to deceive and materially affected acceptance of risk. D.C. Code 1940, § 35-712(f). *Turner v. National Hospitalization*, 52 A.2d 274, 1947 D.C. App.

LEXIS 126 (Cr.App. 1947).

Burden of proof.

Insurer had burden of proving that right to recovery on hospitalization policy was barred by insured's failure to state in application inquiring as to past medical or surgical treatment that insured's cervix had been cauterized, and such burden could be carried by evidence deduced from insured's own witnesses. D.C. Code 1940, § 35-712(f). *Turner v. National Hospitalization*, 52 A.2d 274, 1947 D.C. App. LEXIS 126 (Cr.App. 1947).

Construction and application.

The statute providing that falsity of any statement in application for accident and health policy shall not bar right of recovery thereunder unless made with intent to deceive, or unless materially affecting acceptance of risk or hazard assumed by insurer, was applicable

to insurance company issuing hospitalization policy and chartered in District of Columbia and authorized to do business in District, and to Maryland company assuming policy with consent of insured, where insured continued to live in District and claim arose in District. D.C. Code 1940, § 35-712(f). *Turner v. National Hospitalization*, 52 A.2d 274, 1947 D.C. App. LEXIS 126 (Cr.App. 1947).

Review.

Where defendant moved for finding and judgment at conclusion of plaintiff's evidence and plaintiff moved for judgment after defendant stated that he had no evidence to offer, test to be applied to judgment for defendant from which plaintiff appealed was whether judgment was supported by substantial evidence. *Turner v. National Hospitalization*, 52 A.2d 274, 1947 D.C. App. LEXIS 126 (Cr.App. 1947).

§ 31-4713. Prohibited activities — Securities operations. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1173, ch. 672, ch. V, § 13; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-518. 1973 Ed., § 35-713.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-4714. Prohibited activities—Misrepresentations. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1174, ch. 672, ch. V, § 14; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-519. 1973 Ed., § 35-714.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 13-265. — For

D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4715. Prohibited activities—Discriminations. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1174, ch. 672, ch. V, § 15; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-520.
1973 Ed., § 35-715.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

§ 31-4716. Rights of parties under life policies.

(a) When a policy of insurance, whether heretofore or hereafter issued, is effected by any person on his own life or on another life in favor of some person other than himself having an insurable interest therein, or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof, other than the insured or the person so effecting such insurance or executors or administrators of such insured or the person so effecting such insurance, shall be entitled to its proceeds and avails against the creditors and representatives of the insured and of the person effecting such insurance whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable to the person whose life is insured, if the beneficiary or assignee shall predecease such person; provided, that subject to the statute of limitations the amount of any premiums for said insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy, but the company issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the company shall have written notice by or in behalf of a creditor of a claim to recover for transfer made or premiums paid with intent to defraud creditors with specifications of the amount claimed.

(b) A charitable, benevolent, educational, governmental, or religious institution that is described in § 501(c)(3) or § 170(b)(1)(A) of the Internal Revenue Code or a trust for the benefit of the institution that is qualified as a charitable remainder trust under § 664 or a pooled income fund under § 642(c)(5) of the Internal Revenue Code may acquire an insurable interest in the life of an individual if:

(1) The institution or trust is designated irrevocably as the beneficiary of the insurance proceeds or designated as the owner of the life insurance policy, or both;

(2) The application for the insurance contract is procured and signed by the individual whose life is to be insured; and

(3) Notwithstanding paragraph (1) of this subsection, the insured pays

the premiums for the insurance policy for at least 3 years following the issuance of the policy.

(c) Subsection (b) of this section does not prohibit the insured from retaining all ownership rights conferred by the insurance policy, except the right to loan or borrow value during the premium-paying period or at maturity.

(June 19, 1934, 48 Stat. 1175, ch. 672, ch. V, § 16; Aug. 1, 1947, 61 Stat. 711, ch. 427; Mar. 16, 1995, D.C. Law 10-211, § 2, 41 DCR 8027.)

Prior Codifications. — 1981 Ed., § 35-521. 1973 Ed., § 35-716.

Legislative history of Law 10-211. — Law 10-211, the “Charitable Gift of Life Insurance Proceeds Amendment Act of 1994,” was introduced in Council and assigned Bill No. 10-348, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 15, 1994, it was assigned Act No. 10-348 and transmitted to both Houses of Congress for its review. D.C. Law 10-211 became effective on March 16, 1995.

References in text. — Sections 501(c)(3), 170(b)(1)(A), 664 and 642(c)(5) of the Internal Revenue Code, referred to in (b), are codified as 26 U.S.C. §§ 501(c)(3), 170(b)(1)(A), 664 and 642(c)(5), respectively.

Editor’s notes. — Application of 10-211: Section 3 of D.C. Law 10-211 provided that the act shall be applied retroactively, thereby validating any insurance contract authorized under this act if the individual on whose life the insurance contract was taken is alive on March 16, 1995, even though the insurance contract was entered into before March 16, 1995, and the beneficiary or owner of the policy continues to pay the premiums until maturity.

CASE NOTES

ANALYSIS

Beneficiaries.
Cash surrender value.
Construction and application.
Creditors.
Insurable interests.
Limited partnerships.
Predeceased beneficiaries.

Beneficiaries.

Under statute providing that the lawful beneficiary other than insured or person effecting insurance or “his” executors or administrators shall be entitled to its proceeds against creditors and representatives of insured the word “beneficiary” is an antecedent of the word “his” and statute means that lawful beneficiary or his executors or administrators shall be entitled to the proceeds against creditors and representatives of insured. D.C. Code 1940, § 35-716. *Kindleberger v. Lincoln Nat. Bank of Wash.*, 155 F.2d 281, 1946 U.S. App. LEXIS 2959 (1946).

Cash surrender value.

Cash surrender value of Chapter 7 debtor-insured’s life insurance policy constituted “proceeds” or “avails” of such policy, within meaning of the District of Columbia exemption for proceeds or avails of life insurance policies. In re Davis, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Under the District of Columbia exemption for proceeds or avails of life insurance policies, a

debtor-insured may claim as exempt the cash surrender value of a policy insuring the life of the debtor that is payable to a beneficiary other than the debtor. In re Davis, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Contingently exempt nature of the cash surrender value of a debtor-insured’s life insurance policy under District of Columbia law is analogous to a debtor’s contingently exempt interest in a homestead under Virginia law. In re Davis, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Construction and application.

Where statute, in effect giving proceeds of life policy to personal representatives of beneficiary if beneficiary does not survive insured, was expressly made applicable to policies previously issued, the statute was controlling over contrary provision of policy issued before enactment of statute and such application of the statute did not impair obligation of contract embodied in the policy. D.C. Code 1940, § 35-716. *Kindleberger v. Lincoln Nat. Bank of Wash.*, 155 F.2d 281, 1946 U.S. App. LEXIS 2959 (1946).

Congress intended the District of Columbia exemption for proceeds or avails of life insurance policies to mean that the lawful beneficiary, or the executors or administrators of the beneficiary, should be entitled to the proceeds of the policy against the creditors and representatives of the insured. In re Davis, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Where statutory predecessor of the District of Columbia exemption for proceeds or avails of life insurance policies was "copied" from section of former version of New York insurance law, authority interpreting that section of the New York law was persuasive for purposes of discerning the correct interpretation and application of the D.C. exemption. In *re Davis*, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Under the District of Columbia exemption for proceeds or avails of life insurance policies, debtor-insured's interest in such policy remains exempt only so long as he does not name himself beneficiary. In *re Davis*, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Creditors.

Even if reinstatement of keyman life policy, originally purchased by limited partnership to insure life of president of corporate general partner of limited partnership, as result of president's action of paying premiums which were unpaid and past due constituted "effecting" insurance within meaning of District of Columbia statute providing that when policy of insurance is effected by any person in his own life or on another life in favor of some person other than himself, beneficiary is entitled to proceeds against creditors and representatives of insured and person effecting such insurance, statute did not protect president's surviving spouse, as beneficiary, from action by bankruptcy trustee on behalf of limited partnership, which was not creditor of president, regarding proceeds of policy. D.C. Code 1981, § 35-521. *Federal Kemper Life Assurance Co. v. Wolensky's L.P.* (In *re Wolensky's Ltd. Partnership*), 163 B.R. 615, 1993 Bankr. LEXIS 2053 (1993).

Statute providing that if life policy is affected by person on his own life or for life of another in favor of some person other than himself, beneficiary is entitled to proceeds against creditors and representatives of insured and person effecting such insurance only provides that lawful beneficiary is entitled to proceeds as against creditors of person effectuating insurance and of insured, and does not protect beneficiary from claims by any other creditors who assert interest in proceeds. D.C. Code 1981, § 35-521. *Federal Kemper Life Assurance Co. v. Wolensky's L.P.* (In *re Wolensky's Ltd. Partnership*), 163 B.R. 615, 1993 Bankr. LEXIS 2053 (1993).

Insurable interests.

Beneficiary of debtor's life insurance policy, as his wife, had an insurable interest in his life, as needed to satisfy requirement of District of Columbia exemption for proceeds or avails of life insurance policies. In *re Davis*, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

District of Columbia exemption for proceeds or avails of life insurance policies does not require that the beneficiary have an insurable interest in the policy itself; rather, it requires that the beneficiary have an insurable interest in the life of the person insured by the policy. In *re Davis*, 275 B.R. 134, 2002 Bankr. LEXIS 201 (2002).

Limited partnerships.

Provision of District of Columbia law that when policy of insurance is effected by any person on his own life or on another life in favor of some person other than himself, lawful beneficiary is entitled to proceeds of policy against creditors and representatives of insured and of person effecting such insurance did not apply to keyman life policy obtained by limited partnership on president of corporate general partner; limited partnership was party who "effected" policy at time it was first obtained and limited partnership obtained policy in favor of themselves. D.C. Code 1981, § 35-521. *Federal Kemper Life Assurance Co. v. Wolensky's L.P.* (In *re Wolensky's Ltd. Partnership*), 163 B.R. 615, 1993 Bankr. LEXIS 2053 (1993).

District of Columbia statute providing that lawful beneficiary of life policy is entitled to its proceeds and avails against creditors and representatives of insured and other person effecting such insurance applies only if policy is effected by person on his own life or on the life of another in favor of some person other than himself. D.C. Code 1981, § 35-521. *Federal Kemper Life Assurance Co. v. Wolensky's L.P.* (In *re Wolensky's Ltd. Partnership*), 163 B.R. 615, 1993 Bankr. LEXIS 2053 (1993).

Predeceased beneficiaries.

Where life policy provided that proceeds thereof were to be paid to insured's wife, "if living; otherwise to his executors, administrators or assigns", and insured died 15 months after his wife's death without having changed beneficiary clause, insured's executors, rather than wife's administrators, were entitled to proceeds of policy notwithstanding statute providing that beneficiary's representatives shall be entitled to proceeds of a life policy as against insured's representatives, and though application for policy did not contain the quoted words appearing in policy. D.C. Code 1940, § 35-716. *Horning v. Lindsay*, 169 F.2d 963, 1948 U.S. App. LEXIS 2283 (1948).

Under statute in effect providing that when policy, whether heretofore or hereafter issued, is effected by any person on his own life, the lawful beneficiary or his executors or administrators shall be entitled to its proceeds against creditors and representatives of insured, proceeds of life policy were payable to estate of beneficiary who predeceased insured, notwithstanding insured reserved right to change ben-

eficiary and policy, issued before enactment of statute, provided that interest of beneficiary should vest in insured in event of beneficiary's death before insured. D.C. Code 1940, §§ 30-213, 30-214, 35-716. *Kindleberger v. Lincoln Nat. Bank of Wash.*, 155 F.2d 281, 1946 U.S. App. LEXIS 2959 (1946).

Where insured reserves right to change beneficiary of life policy, interest of beneficiary may be defeated by insured by expedient of chang-

ing beneficiary; but in absence of change, when policy has matured because of insured's death, claim of beneficiary to proceeds cannot be defeated and, if beneficiary has not survived, beneficiary's executors or administrators are entitled under statute to the proceeds against creditors and representatives of insured. D.C. Code 1940, § 35-716. *Kindleberger v. Lincoln Nat. Bank of Wash.*, 155 F.2d 281, 1946 U.S. App. LEXIS 2959 (1946).

§ 31-4716.01. Exemption from legal process — Disability benefits.

No money or other benefit paid, provided, allowed, or agreed to be paid by any company on account of the disability from injury or sickness of any insured person shall be liable to execution, attachment, garnishment, or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law, to pay any debt or liability of such insured person whether such debt or liability was incurred before or after the commencement of such disability, but the provisions of this section shall not affect the assignability of any such disability benefit otherwise assignable, nor shall this section apply to any money income disability benefit in an action to recover for necessities contracted for after the commencement of disability covered by the disability clause or contract allowing such money income benefit.

(June 19, 1934, 48 Stat. 1175, ch. 672, ch. V, § 16a.)

Prior Codifications. — 1981 Ed., § 35-522. 1973 Ed., § 35-717.

CASE NOTES

ANALYSIS

Debts and liabilities.
Divorce.
Jurisdiction.
Necessaries.

Debts and liabilities.

In statute exempting disability insurance from execution for payment of "any debt or liability", the quoted words were to be construed in the light of the nature of the fund exempted, the purposes for which it ordinarily is created, and the circumstances in which it becomes available to the insured and the uses normally made of it. D.C. Code Supp. I V, T. 5, § 220p. *Schlaefter v. Schlaefter*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

Divorce.

Disability benefits payable to husband by insurer could be sequestered for satisfaction of husband's alimony obligation to divorced wife notwithstanding policies provided for continuance of disability payments only during husband's total and permanent disability and re-

quired him to make periodic proof that disability continued as against contention that the obligation of insurer to make disability payments did not constitute a "debt" or "income". D.C. Code Supp. I V, T. 5, § 220p. *Schlaefter v. Schlaefter*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

Even though life policies designated payments which insurer was under obligation to make to insured as "disability benefits", such designation did not make the insurer a trustee to see that the funds were applied to particular purposes by or for the benefit of the insured, as regards question whether the payments could be sequestered for satisfaction of claim of insured's divorced wife for alimony. D.C. Code Supp. I V, T. 5, § 220p. *Schlaefter v. Schlaefter*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

Under statute exempting disability insurance from execution for payment of any "debt" or "liability" of insured, disability benefits of divorced husband were not exempt from application to wife's claim for alimony under limited divorce decree, since the obligation on which

wife's claim was based was not a "debt" or a "liability" in the ordinary usages of those terms. D.C. Code Supp. I V, T. 5, § 220p; D.C. Code 1929, T. 14, §§ 70-73, 75; D.C. Code Supp. I V, T. 14, § 63. *Schlaefer v. Schlaefer*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

Jurisdiction.

Where court had jurisdiction of parties in divorced wife's proceeding against husband and his insurer to sequester disability benefit payments for satisfaction of alimony, the court had jurisdiction of the subject matter notwithstanding the husband was a nonresident and the insurer was a foreign corporation and the benefits were payable at the home office of the insurer. D.C. Code 1929, T. 24, Sec. 378. *Schlaefer v. Schlaefer*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

Necessaries.

As regards application of the statute exempting disability insurance from execution, for the

head of a family the essentials of sustenance for his dependents remain "necessaries" as much when he is disabled as when he is well and employed since disability does not relieve him of obligation of support though it may affect the extent to which he can perform it. D.C. Code Supp. I V, T. 5, § 220p. *Schlaefer v. Schlaefer*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

A husband's disability does not terminate a wife's power to pledge husband's credit for necessities, whether for her own or for his children's support. *Schlaefer v. Schlaefer*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

The usual purpose of "exemptions" is to release the person exempted from the pressure of claims hostile to his dependents' essential needs as well as his own personal ones not to relieve him of family obligations and destroy what may be the family's last and only security short of public relief. *Schlaefer v. Schlaefer*, 112 F.2d 177, 1940 U.S. App. LEXIS 4260 (1940).

§ 31-4717. Exemption from legal process — Group life policy or proceeds.

No policy of group life insurance, nor the proceeds thereof when paid to any employee or employees thereunder, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law, to pay any debt or liability of such employee, or his beneficiary, or any other person who may have a right thereunder, either before or after payment; nor shall the proceeds thereof, when not made payable to a named beneficiary, constitute a part of the estate of the employee for the payment of his debts.

(June 19, 1934, 48 Stat. 1176, ch. 672, ch. V, § 17.)

Prior Codifications. — 1981 Ed., § 35-523. 1973 Ed., § 35-718.

§ 31-4718. Fraudulent statements or representations against companies. [Repealed].

Repealed.

(June 19, 1934, 48 Stat. 1176, ch. 672, ch. V, § 18; Apr. 3, 2001, D.C. Law 13-265, § 126(a), 48 DCR 1225, redesignated § 301, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-524. 1973 Ed., § 35-719.

Legislative history of Law 13-265. — For D.C. Law 13-265, see notes following § 31-2231.01.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-4719. Authority to hold proceeds under trust or agreement.

Any life company licensed under the laws of the District shall have power to hold the proceeds of any policy issued by it under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries and with such exemptions from the claims of creditors or beneficiaries other than the policyholder as shall have been agreed to in writing by such company and the policyholder. Such insurance company shall not be required to segregate funds so held, but may hold them as a part of its general corporate assets.

(June 19, 1934, 48 Stat. 1176, ch. 672, ch. V, § 19.)

Prior Codifications. — 1981 Ed., § 35-525. 1973 Ed., § 35-720.

§ 31-4720. Calculations of premiums and reserves.

If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in § 31-4701(c)(3) and (d); provided, that for any life insurance policy issued on or after January 1, 1987, for which the gross premium in the 1st policy year exceeds that of the 2nd year and for which no comparable additional benefit is provided in the 1st year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in § 31-4701(c)(5), ignoring subsection (c)(5)(B) of § 31-4701. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with § 31-4701(c)(5), including subsection (c)(5)(B) of § 31-4701, and the minimum reserve calculated in accordance with this section.

(June 19, 1934, 48 Stat. 1176, ch. 672, ch. V, § 20; Oct. 13, 1978, D.C. Law 2-120, § 10, 25 DCR 1519; Mar. 14, 1985, D.C. Law 5-160, § 3(g), 32 DCR 39.)

Section references. — This section is referred to in § 31-4701.

Prior Codifications. — 1981 Ed., § 35-526.

1973 Ed., § 35-721.

Legislative history of Law 2-120. — For legislative history of D.C. Law 2-120, see His-

torical and Statutory Notes following § 31-4701.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Editor's notes. — References in D.C. Law

5-160 in § 31-4701 and in this section have been translated accurately to reflect the D.C. Code numbering system for § 31-4701(c). It should be noted, however, that the numbering system used by the D.C. Code and the numbering system used by the Organic Law differ markedly.

§ 31-4721. Acceptance and recordation of premiums on industrial life or sick-benefit policies.

(a) No industrial insurance company or agent thereof shall accept any money in payment of premiums which are in arrears on any industrial life or industrial sick-benefit insurance policy which has lapsed and which the insured seeks to reinstate, unless such payment shall amount at least to the total of all premiums in arrears or unless such payment shall, under the regulations of the company, make the policy immediately eligible for reinstatement, subject only to evidence of insurability.

(b) Every current premium shall be correctly recorded by the agent or by the company in the premium receipt book of the insured at the time the premium is paid.

(c) Every advance premium paid by an industrial life or industrial sick-benefit policyholder shall be recorded in the receipt book of the insured in exactly the same manner as current premiums are recorded, and accurate entry thereof shall be made in the record book of the agent; provided, however, that failure so to do shall not invalidate the policy.

(June 19, 1934, ch. 672, ch. V, § 21; May 4, 1950, 64 Stat. 104, ch. 157, § 7.)

Prior Codifications. — 1981 Ed., § 35-527. 1973 Ed., § 35-722.

§ 31-4722. Industrial life policies — Required provisions.

(a) No policy of industrial life insurance shall be delivered or issued for delivery in the District unless it contains in substance the following provisions, or provisions which in the opinion of the Commissioner are more favorable to the policyholders:

(1) A provision that all premiums after the first shall be payable in advance, either at the home office of the company or to an agent of the company;

(2) A provision that the insured is entitled to a grace period of at least 28 days within which the payment of any premiums after the first may be made, and during which period of grace the policy shall continue in full force, but in case the policy becomes a claim during the said period of grace before the overdue premium is paid, the amount of such premium may be deducted from any amount payable under the policy in settlement;

(3) A provision that, except as otherwise expressly provided by law, the policy shall constitute the entire contract between the parties and shall be incontestable after it has been in force during the lifetime of the insured for a period of not more than 2 years from its date, except for nonpayment of premiums and except for violations of the conditions of the policy relating to

naval or military service in time of war, and, at the option of the company, provisions relative to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident may also be excepted; if a copy of the application be attached to the policy, a provision that all statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement or statements shall be used in defense of a claim under the policy unless contained in the attached written application;

(4) A provision that if it shall be found at any time before final settlement under the policy that the age of the insured (or the age of any other person considered in determining the premium) has been misstated, the amount payable under the policy shall be such as the premium would have purchased at the correct age, according to the company's rate at date of issue;

(5) If the policy is a participating policy, a provision indicating the conditions under which the company shall periodically ascertain and apportion any divisible surplus accruing to the policy;

(6) A provision for nonforfeiture benefits and cash surrender values in accordance with the requirements of § 31-4705.01 or § 31-4705.02;

(7) A provision specifying the options, if any, to which the policyholder is entitled in the event of default in a premium payment;

(8) A provision that if in event of default in premium payments the value of the policy shall have been applied to the purchase of other insurance as provided for in this section, and if such insurance shall be in force and the original policy shall not have been surrendered to the company and cancelled, the policy may be reinstated within 2 years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums and the payment or reinstatement of any other indebtedness to the company upon said policy, with interest on said premium and indebtedness at the rate of not exceeding 6 per centum per annum payable annually;

(9) A provision that when a policy shall become a claim by the death of the insured settlement shall be made upon receipt of due proof of death; and

(10) Title on the face and on the back of the policy briefly describing its form.

(b) Any of the foregoing provisions or portions thereof not applicable to single premium or nonparticipating or term policies shall, to that extent, not be incorporated therein; and any such policy may be issued or delivered in the District which in the opinion of the Commissioner contains provisions on any 1 or more of the several foregoing requirements more favorable to the policyholder than hereinbefore required. The provisions of this section shall not apply to policies issued or granted in exchange for lapsed or surrendered policies. Nothing contained in paragraph (3) of subsection (a) of this section shall apply to applications for reinstatement. A reinstated policy shall be contestable on account of fraud or misrepresentation of material facts pertaining to the reinstatement, for the same period after reinstatement as provided in the policy with respect to the original issue.

(June 19, 1934, ch. 672, ch. V, § 22; May 4, 1950, 64 Stat. 104, ch. 157, § 7; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-528.
1973 Ed., § 35-723.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4723. Industrial life policies — Prohibited provisions.

No policy of industrial life insurance shall be delivered or issued for delivery, in the District, if it contains any of the following provisions:

(1) A provision limiting the time within which any action at law or in equity may be commenced to less than 3 years after the cause of action shall accrue;

(2) Except for provisions relating to misstatement of age, suicide, aviation, and military or naval service in time of war, a provision for any mode of settlement at maturity, after the expiration of the contestable period of the policy, of less value than the amount insured on the face of the policy plus dividend additions, if any, less any indebtedness to the company on or secured by the policy, and less any premium that may, by the terms of the policy, be deducted. This paragraph shall not apply to any nonforfeiture provision;

(3) A provision for forfeiture of the policy for failure to repay any loan on the policy, or to pay interest on such loan, while the total indebtedness on the policy, including interest, is less than the loan value thereof;

(4) A provision to the effect that the agent soliciting the insurance is the agent of the person insured under said policy, or making the acts or representations of such agent binding upon the person so insured under said policy;

(5) A provision permitting the payment of funeral benefits in merchandise or services, or permitting the payment of any benefits other than in lawful money of the United States;

(6) A provision whereby the benefits or any part thereof accruing under such policy upon the death of a person insured may be paid to any designated undertaker or undertaking firm or corporation or to any person or persons engaged in or connected with such business, without the written consent of the person or persons to whom such benefits would otherwise be paid, or so as in any way to deprive the personal representative or family of the deceased of the advantages of competition in procuring and purchasing supplies and services in connection with the burial of the person insured; or

(7) A provision that the liability of the company by reason of the insured's death shall be limited to less than the face amount of the policy if the death of the insured results from a specified kind or character of disease.

(June 19, 1934, ch. 672, ch. V, § 23; May 8, 1950, 64 Stat. 104, ch. 157, § 7.)

Prior Codifications. — 1981 Ed., § 35-529.

1973 Ed., § 35-724.

§ 31-4724. Access to psychologists or optometrists under group health insurance policy.

(a) No policy of group health insurance shall be delivered or issued in the

District of Columbia or be issued or amended to cover any resident of the District of Columbia if it contains a provision which would restrict access to psychologists or optometrists. When a policy relating to group health insurance requires payment or reimbursement for services which may be performed by a duly licensed psychologist or optometrist, any person covered by the policy shall be free to select and have direct access to such psychologist or optometrist without supervision or referral by a practitioner of the healing art and shall be entitled under the policy to have payment or reimbursement made for services performed.

(b) No policy of group health insurance shall be delivered or issued in the District or be issued or amended to cover any resident of the District if it does not contain a provision which:

(1) For a policy issued or renewed after April 15, 1995, covers a minor grandchild, niece, or nephew of an employee of the District of Columbia if the minor grandchild, niece, or nephew is under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session; and

(2) For a policy issued or renewed after April 15, 1996, covers a minor grandchild, niece, or nephew under the primary care of the insured, and if the legal guardian of the minor grandchild, niece, or nephew, if other than the insured, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece or nephew during the time that the District of Columbia public schools are in regular session.

(June 19, 1934, 48 Stat. 1156, § 24, as added Feb. 11, 1982, D.C. Law 4-66, § 2(b), 28 DCR 5040; Aug. 25, 1994, D.C. Law 10-158, § 3, 41 DCR 4881.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Section references. — This section is referred to in § 31-4712.

Prior Codifications. — 1981 Ed., § 35-530.

Legislative history of Law 4-66. — For

legislative history of D.C. Law 4-66, see Historical and Statutory Notes following § 31-4712.

Legislative history of Law 10-158. — For legislative history of D.C. Law 10-158, see Historical and Statutory Notes following § 31-4712.

§ 31-4725. Policy language simplification standards.

(a) Except as provided under § 31-4727, no policy forms shall be delivered or issued for delivery in the District of Columbia after the operative date of this section, unless the forms qualify under the following standards;

(1) The text of the form scores at least 40 on the Flesch reading ease test presented to the Commissioner by the National Association of Insurance Commissioners after 1980 or on another comparable test described in subsection (c) of this section.

(2) The forms shall be printed in at least 10-point type and shall be 1-point leaded.

(3) The style, the arrangement, and the overall appearance of the form shall not unduly highlight a portion of the text, an endorsement, or a rider.

(4) If the policy has more than 3,000 words on 3 pages or has more than 3 pages, then the form shall contain a table of contents or an index of the principal portions of the text.

(b) A Flesch reading ease test score shall be measured by the following method:

(1)(A) For forms containing no more than 10,000 words, the entire form shall be analyzed.

(B) For policy forms containing more than 10,000 words, the readability of 2 different 200 word samples, per page of text, may be analyzed instead of the entire form.

(C) The samples shall be separated by at least 20 printed lines.

(2)(A) The number of words and sentences shall be counted and the total number of words divided by the number of sentences.

(B) The quotient shall be multiplied by 1.015.

(3)(A) The total number of syllables shall be counted and divided by the total number of words.

(B) The quotient shall be multiplied by 84.6.

(4) The sum of the products described in paragraphs (2) and (3) of this subsection, subtracted from 206.835, equals the Flesch reading ease score.

(5) For paragraphs (2), (3), and (4) of this subsection, the following shall apply:

(A) A contraction, hyphenated word, number, and isolated letter, when separated in the text by spaces shall be counted as 1 word.

(B) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

(C) The following shall not be counted in computations described in this subsection:

(i) The company name and address.

(ii) The policy name, number, or title.

(iii) The table of contents and index.

(iv) The captions and subchapters.

(v) The specification pages, schedules, or tables.

(vi) Policy language drafted to conform to law or a collectively bargained agreement.

(vii) Policy language which is medical terminology or defined in the policy.

(D) The company shall identify the language exempted under subparagraph (C) of this paragraph and certify, in writing, that the language should be exempted under subparagraph (C) of this paragraph.

(c) Any other reading test may be approved by the Commissioner as an alternative to the Flesch reading ease test if the alternative is comparable to the Flesch reading ease test.

(d)(1) Filings of forms shall be accompanied by a certificate signed by an

officer of the company and stating that the form scored successfully on the test or that the score was inadequate but should be approved under § 31-4726.

(2) The Commissioner may require the submission of information to verify the certification described in paragraph (1) of this subsection.

(e) At the option of the company, riders, endorsements, applications, and other forms made part of the policy form may be scored separately or as part of the policy.

(f)(1) A form complying with subsection (a) of this section shall be approved if the form protects policyholders and claimants at least as favorably as laws which otherwise would invalidate the use of the forms.

(2) A policy written in a language other than English and used in the District of Columbia shall be considered in compliance with subsection (a)(1) of this section if the company certifies that the policy has been translated from a policy written in English and complying with subsection (a)(1) of this section.

(June 19, 1934, ch. 672, ch. V, § 25, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39; Feb. 24, 1987, D.C. Law 6-192, § 25(h), 33 DCR 7836; May 21, 1997, D.C. Law 11-268, § 10(j), 44 DCR 1730.)

Section references. — This section is referred to in §§ 31-3503, 31-4726, 31-4727, 31-4729, and 31-4730.

Prior Codifications. — 1981 Ed., § 35-531.

Legislative history of Law 5-160. — Law 5-160, the “Life Insurance Amendments Reform Act of 1984,” was introduced in Council and assigned Bill No. 5-471, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 20, 1984, and December 4, 1984, respectively. Signed by the Mayor on December 7, 1984, it was assigned

Act No. 5-225 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-192. — For legislative history of D.C. Law 6-192, see Historical and Statutory Notes following § 31-4703.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-4701.

§ 31-4726. Commissioner’s review of test.

(a) The Commissioner, in his discretion, may, under subsection (b) of this section, permit the use of a form that scores inadequately under § 31-4725(a)(1).

(b) Before the Commissioner permits the use of inadequately scoring forms, the Commissioner shall find that:

(1) A lower score more accurately reflects the readability of the form.

(2) The particular nature of the form or of a type of form warrants a lower passing score than required by § 31-4725(a)(1).

(3) Policy language drafted to conform with state law or state agency interpretation of the law has impaired the readability of the rest of the policy or has otherwise lowered the score for the rest of the policy.

(June 19, 1934, ch. 672, ch. V, § 26, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39; Feb. 24, 1987, D.C. Law 6-192, § 25(i), 33 DCR 7836; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(e), 45 DCR 745.)

Section references. — This section is referred to in §§ 31-3503, 31-4725, 31-4727, and 31-4730.

Prior Codifications. — 1981 Ed., § 35-532.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Legislative history of Law 6-192. — For legislative history of D.C. Law 6-192, see His-

torical and Statutory Notes following § 31-4703.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4705.02.

§ 31-4727. Applicability of §§ 31-4725 through 31-4730.

(a) Except as provided in subsection (b) of this section, §§ 31-4725 through 31-4730 shall apply to all policies used in the District of Columbia.

(b) Sections 31-4725 through 31-4730 shall not apply to the following:

(1) A policy which is a security under federal legislative jurisdiction.

(2)(A) Except as provided in subparagraph (B) of this paragraph, a group policy covering 1,000 or more lines when issued, other than a group credit life insurance policy or a group credit health insurance policy.

(B) No certificate issued pursuant to a group policy used in the District of Columbia may be exempt.

(3) A group annuity contract which finances pension, profit-sharing, or deferred compensation plans.

(4) A form used in connection with a contractual provision for a policy on a form permitted to be issued before the approval dates in § 31-4730 for similar forms.

(5) The renewal of a policy used before the approval dates in § 31-4730 for similar forms.

(June 19, 1934, ch. 672, ch. V, § 27, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39; Feb. 24, 1987, D.C. Law 6-192, § 25(j), 33 DCR 7836.)

Section references. — This section is referred to in §§ 31-3503, 31-4725, and 31-4730.

Prior Codifications. — 1981 Ed., § 35-533.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Legislative history of Law 6-192. — For legislative history of D.C. Law 6-192, see Historical and Statutory Notes following § 31-4703.

§ 31-4728. Regulations.

The Mayor shall issue rules to implement the provisions of this chapter pursuant to subchapter I of Chapter 5 of Title 2.

(June 19, 1934, ch. 672, ch. V, § 28, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39.)

Section references. — This section is referred to in §§ 31-3503, 31-4727, 31-4729, and 31-4730.

Prior Codifications. — 1981 Ed., § 35-534.

Legislative history of Law 5-160. — For legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

§ 31-4729. Construction of §§ 31-4725 through 31-4730.

Sections 31-4725 through 31-4730 shall not be construed to invalidate a law permitting the use of a policy form which has been filed for the period required by local legislation governing the forms of policies.

(June 19, 1934, ch. 672, ch. V, § 29, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39.)

Section references. — This section is referred to in §§ 31-3503, 31-4727, and 31-4730.

Prior Codifications. — 1981 Ed., § 35-535.

Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

CASE NOTES

Loans.

District of Columbia Loan Shark Act is applicable to loans made by life insurance companies in regular course of their business and thus such companies, until 1963, were not exempt from requirement of obtaining license in order to make loans at rate of interest in excess of 6%, notwithstanding contentions that Act does not apply to insurance companies which “invest” their funds by making loans secured by real estate, that, in view of comprehensive regula-

tion of insurance companies under certain title of District of Columbia Code, they cannot be subject to licensing regulation of lending activities under Act, and that Act is not intended to apply to large loans made by “institutional lenders” and secured by real estate. D.C. Code §§ 26-601, 26-610, 26-610(a), 28-3301, 35-105, 35-535, 35-535(14)(f), 47-1574, 47-1806. In re Parkwood, Inc., 461 F.2d 158, 1971 U.S. App. LEXIS 7189 (C.A.D.C. 1971).

§ 31-4730. Operative dates of §§ 31-4725 through 31-4730.

(a)(1) Except as described in § 31-4727, §§ 31-4725 through 31-4730 apply to policy forms filed 2 years after March 14, 1985.

(2) No form shall be used in the District of Columbia 5 years after March 14, 1985, unless the form complies with § 31-4725 or unless the Commissioner approves the form under § 31-4726.

(3)(A) A form permitted to be used before 5 years after March 14, 1985, and complying with § 31-4725 need not be refiled to be approved under either § 31-4725 or § 31-4726.

(B) The forms described in subparagraph (A) of this paragraph may be used in the District of Columbia after the company files with the Commissioner a list of the forms used by the company and qualifying for the subparagraph (A) exception, the form number for each form, and, for each form, the certificate described in § 31-4725(d).

(b) For individual forms and in the discretion of the Commissioner, the Commissioner may extend the deadlines described in subsection (a) of this section.

(June 19, 1934, ch. 672, ch. V, § 30, as added Mar. 14, 1985, D.C. Law 5-160, § 3(h), 32 DCR 39; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 23(f), 45 DCR 745.)

Section references. — This section is referred to in §§ 31-3503, 31-4727, and 31-4729.

Prior Codifications. — 1981 Ed., § 35-536.
Legislative history of Law 5-160. — For

legislative history of D.C. Law 5-160, see Historical and Statutory Notes following § 31-4725.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-4701.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-4705.02.

SUBDIVISION B. GENERAL.

CHAPTER 48. INDUSTRIAL LIFE INSURANCE.

Sec.

31-4801. Applicability of provisions.

31-4802. Policies — Defenses to validity.

31-4803. Policies — Incontestability.

Sec.

31-4804. Policies — Assignment.

31-4805. Beneficiaries and claimants.

§ 31-4801. Applicability of provisions.

Policies of industrial weekly payment life insurance after June 4, 1934, issued or delivered in the District of Columbia shall be subject to the following conditions, in addition to any others prescribed by law and not inconsistent with the provisions of this chapter.

(June 4, 1934, 48 Stat. 834, ch. 373, § 1.)

Prior Codifications. — 1981 Ed., § 35-901. 1973 Ed., § 35-1001.

CASE NOTES

Fraternal benefit organizations.

Plaintiff was not entitled to a mandatory injunction requiring superintendent of insurance to renew its permit to do insurance business as a fraternal beneficial association, even though it was not qualified under statute, on ground that persons in control of plaintiff had acted in reliance on expired permits which were issued by superintendent's predecessors in office and that superintendent was "estopped" from refusing to renew permit. D.C. Code 1940, §§ 35-901, 35-906, 35-907. National Hospital

Service Soc. v. Jordan, 128 F.2d 460, 1942 U.S. App. LEXIS 3610 (1942).

A corporation which did not question finding that it was not qualified under statute to do insurance business as a fraternal beneficial association had no "legal right" to a license and could not invoke an estoppel to obtain a license forbidden by statute. D.C. Code 1940, §§ 35-901, 35-906, 35-907. National Hospital Service Soc. v. Jordan, 128 F.2d 460, 1942 U.S. App. LEXIS 3610 (1942).

§ 31-4802. Policies — Defenses to validity.

If payment of such a policy shall be refused because of unsound health at or prior to the date of the policy, the good faith of both applicant and insured shall constitute a material element in determining the validity of the policy; and it shall not be held invalid because of unsound health unless the insurer shall prove that, at or before the date of issue of the policy, the insured or applicant had knowledge of, or reason to know, the facts on which the defense is based, or shall prove that the insurance was procured by the insured or applicant in bad faith or with intent to defraud the company, any provision, agreement, condition, warranty, or clause contained in said policy, or endorsed thereon, or added or attached thereto, to the contrary notwithstanding. Proof by the insurer of fraud, intent to deceive, unsound health, bad faith, breach of warranty or condition precedent, or other matter of defense, shall be subject to the provisions of § 31-5203.

(June 4, 1934, 48 Stat. 834, ch. 373, § 2.)

Cross references. — Formal requisites of insurance policies, see § 31-4703 et seq.

Prior Codifications. — 1981 Ed., § 35-902. 1973 Ed., § 35-1002.

CASE NOTES

ANALYSIS

Applications.

Burden of proof.

Construction of policies.

Evidence.

Nonpayment of premiums.

Unsound health.

Applications.

Where written application, if there was one, was not delivered with industrial life policy, but policy by its terms constituted the entire agreement, the statute requiring a copy of the application to be delivered with each life policy issued by an insurer did not prevent insurer from making any defense that it had under the terms of the policy. D.C. Code 1929, T. 5, § 183. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

Burden of proof.

Where forfeiture clause invoked in action on industrial life policy was conditioned on proof that insured had been hospitalized, had undergone an operation, or had been attended by a physician for a serious disease or injury, and had failed to disclose the facts, effect of statute providing that if payment is refused because of unsound health at or before date of policy, good faith of applicant and insured shall constitute a material element in determining validity of policy, was to shift the burden of proof and to make insured's good faith concerning representations on which policy issued the test and by its terms to impose on insurer the burden of proving the contrary. D.C. Code Supp. V, T. 5, § 181b. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

In action on an industrial life policy with defense that insured had been attended by physician for a serious disease which resulted in death and that such was not endorsed on the policy as required by the terms thereof, record established that statutory burden of proof was actually placed upon the insurer to prove the defense by the trial court. D.C. Code 1951, § 35-1002. *Ferguson v. Quaker City Life Ins. Co.*, 129 A.2d 189, 1957 D.C. App. LEXIS 201 (Cr.App. 1957).

Where insurer sets up defense of insured's unsound health prior to issuance of policy, whether defense is based on application or on policy provision, insurer has burden of proving that applicant or insured acted in bad faith. D.C. Code 1951, §§ 35-203, 35-1002. *Walton v.*

Sun Life Ins. Co., 115 A.2d 310, 1955 D.C. App. LEXIS 187 (Cr.App. 1955).

Statute regarding burden of proof where payment of policy is refused because of unsound health of insured, casts the burden of proof on insurer and requires that it establish that the ailment was serious and that the insured knew, or had reason to know, the facts on which the defense is based. D.C. Code 1940, § 35-1002. *Washington Nat. Ins. Co. v. Stanton*, 31 A.2d 680, 1942 D.C. App. LEXIS 37 (Cr.App. 1942).

Construction of policies.

The rule of liberal construction of industrial life policy in favor of holder thereof is inapplicable where contract is clear and definite. *Capital City Life Ins. Co. v. Saunders*, 65 A.2d 588, 1949 D.C. App. LEXIS 180 (Cr.App. 1949).

Evidence.

In action on industrial life policy, hospital records made by an intern from information given him by insured showing that when policy was issued insured was suffering from heart disease and that she had received medical treatment before issuance of policy were inadmissible under statute forbidding disclosure by a physician of any information obtained by him in his professional capacity, since an intern, though not licensed to practice, is a "physician" within the statute. D.C. Code 1929, T. 9, § 20. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

In action on industrial life policy, physician's testimony that he had been called to attend and had attended and treated insured in a professional capacity during two-year period immediately preceding issuance of policy was not inadmissible under statute forbidding disclosure by a physician of any information obtained by him in his professional capacity. D.C. Code 1929, T. 9, § 20. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

In action on industrial life policy, evidence of hospital records showing autopsy on insured was not inadmissible under statute forbidding disclosure by a physician of any information obtained by him in his professional capacity, since the relation between a surgeon performing an autopsy and the body of a dead person is not a "physician and patient relation." D.C. Code 1929, T. 9, § 20. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

Nonpayment of premiums.

An industrial life policy which had lapsed for non-payment of premiums was not revived by

beneficiary's tender of premiums in arrears, where receipt given by insurer's agent clearly stated that insured and beneficiary warranted present good health of insured, and insurer never entered premium in receipt book and made no later demand for payment of premiums accruing, and warranty of good health was false, and insurer had not waived the warranty. *Capital City Life Ins. Co. v. Saunders*, 65 A.2d 588, 1949 D.C. App. LEXIS 180 (Cr.App. 1949).

Unsound health.

The design of the statute providing that if payment of a life policy is refused because of unsound health at or before date of policy, good faith of applicant and insured shall constitute a material element in determining validity of policy, is to make its terms applicable in all cases in which the defense is that the insured had suffered, before issuance of policy, a serious injury or disease, and had concealed the truth from the insurer. D.C. Code Supp. V, T. 5, § 181b. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

In action on industrial life policy, evidence concerning insured's attendance by a physician for a serious disease within two years preceding issuance of policy was sufficient for jury on question of insured's bad faith in procuring policy and intent to defraud insurer. D.C. Code Supp. V, T. 5, § 181b. *Eureka-Maryland Assur. Co. v. Gray*, 121 F.2d 104, 1941 U.S. App. LEXIS 3169 (1941).

In action by beneficiary against insurer on industrial life policy, wherein insurer defended on provision of policy that policy is voidable if, within two years before date of issue of policy, insured received treatment for serious disease or physical condition, evidence was sufficient to sustain insurer's burden under statute of proving insured's unsound health, knowledge of insured's unsound health or reason to know thereof, and bad faith of insured or beneficiary or intent to defraud insurer. D.C. Code 1951, § 35-1002. *Ferguson v. Quaker City Life Ins.*

Co., 146 A.2d 580, 1958 D.C. App. LEXIS 345 (Cr.App. 1958).

In action to recover under life policy, wherein insurer relied on policy provision that policy was voidable if, within two years prior to date of issuance, insured had undergone hospitalization for condition of a serious nature, test was insured's good faith, and trial court erred in failing to make a finding on that issue. D.C. Code 1951, §§ 35-203, 35-1002. *Walton v. Sun Life Ins. Co.*, 115 A.2d 310, 1955 D.C. App. LEXIS 187 (Cr.App. 1955).

Where insurer defends action on insurance policy on ground of unsound health of insured at or prior to date of policy, and there is no conflict in evidence or no contradiction of showing of existence of serious disease, the trial judge must take the case from the jury and rule as a matter of law in favor of insurer. D.C. Code 1940, § 35-1002. *Washington Nat. Ins. Co. v. Stanton*, 31 A.2d 680, 1942 D.C. App. LEXIS 37 (Cr.App. 1942).

In action on industrial life policy where insurer defended on ground that insured was suffering from serious disease of arthritis at time of issuance of policy but testimony of insured's physician directly rebutted insurer's contention that insured had either real or imputed knowledge of alleged seriousness of her condition and insured's physician testified that the ailment was serious only in sense that it temporarily restricted motion of certain parts of the body, evidence was sufficient for jury. D.C. Code 1940, § 35-1002. *Washington Nat. Ins. Co. v. Stanton*, 31 A.2d 680, 1942 D.C. App. LEXIS 37 (Cr.App. 1942).

Where insurer defends action on insurance policy on ground of unsound health of insured at time or prior to date of policy and plaintiff creates a substantial issue of fact on question of unsound health, it becomes a question for the jury and not for the court. D.C. Code 1940, § 35-1002. *Washington Nat. Ins. Co. v. Stanton*, 31 A.2d 680, 1942 D.C. App. LEXIS 37 (Cr.App. 1942).

§ 31-4803. Policies — Incontestability.

Every such policy shall be incontestable upon any ground relating to health after 2 years from its date of issue (notwithstanding a longer period may be named therein), provided the insured shall be alive at the end of said period. If the policy by its terms shall be incontestable after a shorter period than herein provided the terms of the policy with regard to such period of limitation shall govern.

(June 4, 1934, 48 Stat. 834, ch. 373, § 3.)

Cross references. — Formal requisites of insurance policies, see § 31-4703 et seq.

Prior Codifications. — 1981 Ed., § 35-903. 1973 Ed., § 35-1003.

CASE NOTES

Policy terms.

The words "immediate full benefit", as used in industrial life policy, did not make the policy incontestable or require that amount thereof be paid regardless of cause of death, but meant nothing more than that full amount of policy would be paid immediately upon death. *Walker v. Superior Life Ins. Co.*, 62 A.2d 192, 1948 D.C. App. LEXIS 212 (Cr.App. 1948).

The words "immediate full benefit", appearing on cover page of industrial life policy, did not preclude insurer from rejecting claim upon the policy for insured's death five days after policy had been issued as result of heart attack under provision in limitation of liability clause, excluding heart disease and other enumerated diseases contracted at any time before or

within first year from date of policy, where limitation of liability clause appeared inside the policy in the boldest type of any text matter therein. *Walker v. Superior Life Ins. Co.*, 62 A.2d 192, 1948 D.C. App. LEXIS 212 (Cr.App. 1948).

Where industrial life policy sued upon contained provision that terms could not be changed or waived, except by endorsement thereon or rider attached thereto signed by president or secretary of insurer, refusal to permit beneficiary to testify concerning conversations she had with insurer's soliciting agent concerning phrase "immediate full benefit" in the policy was not error. *Walker v. Superior Life Ins. Co.*, 62 A.2d 192, 1948 D.C. App. LEXIS 212 (Cr.App. 1948).

§ 31-4804. Policies — Assignment.

Nothing contained in the terms of any such policy shall operate to prevent its valid assignment by the insured; but the company issuing the policy so assigned shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the company shall have written notice of such assignment.

(June 4, 1934, 48 Stat. 835, ch. 373, § 4.)

Prior Codifications. — 1981 Ed., § 35-904. 1973 Ed., § 35-1004.

§ 31-4805. Beneficiaries and claimants.

Any individual designated with the consent of the insurer, evidenced by the signature of its president or secretary, or designated upon a form furnished by and filed with the insurer, as beneficiary of such a policy shall be entitled to the proceeds of such policy after the death of the insured in priority to all other claimants, and may sue in his own name for such proceeds if payment is refused by the insurer; provided, that upon the expiration of 15 days after the death of the insured, unless proof of claim in the manner and form required by the policy, accompanied by the policy for surrender, has theretofore been made by or on behalf of such designated beneficiary, the insurer may pay to any other claimant permitted by the policy. A person specified as one to whom the insured desires payment made, but not formally designated as beneficiary, shall be deemed a beneficiary for the purposes of this section, provided such designation be made in writing and filed with the company during the lifetime of the insured.

(June 4, 1934, 48 Stat. 835, ch. 373, § 5.)

Prior Codifications. — 1981 Ed., § 35-905. 1973 Ed., § 35-1005.

CHAPTER 49. LIFE INSURANCE ACTUARIAL OPINION OF RESERVES.

Sec.

31-4901. Actuarial opinion of reserves.

§ 31-4901. Actuarial opinion of reserves.

(a) *General requirements and guidelines.* —

(1) Every life insurance company doing business in the District of Columbia shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Mayor, by regulation, are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with § 31-4701 and all applicable laws of the District of Columbia. The Mayor by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) For each year ending on or after December 31, 1993, the opinion shall be submitted with the annual statements and reports required by §§ 31-203 [repealed] and 31-5202, and Chapter 3 of this title.

(3) The opinion shall apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the Mayor as specified by regulation.

(4) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on any additional standards the Mayor may prescribe by regulation.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the Mayor may accept the opinion filed by that company with the insurance supervisory official of another state if the Mayor determines that the opinion reasonably meets the requirements applicable to a company domiciled in the District of Columbia.

(6) For the purposes of this section, the term “qualified actuary” means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations.

(7) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the Mayor, for any act, error, omission, decision, or conduct with respect to the actuary’s opinion.

(8) Disciplinary action by the Mayor against the company or the qualified actuary shall be defined in regulations by the Mayor.

(8A) Except as provided in paragraph (11) of this subsection, documents, materials, or other information in the possession or control of the Department of Insurance, Securities, and Banking that are a memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum (individually and collectively, “memorandum”), shall be confidential and privileged; shall not be subject to subchapter II of Chapter 5 of Title 2; shall not be subject to subpoena; and shall not be subject to discovery or admissible in evidence in a private civil action;

provided, that the Commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(8B) The Commissioner or any person who received documents, materials, or other information while acting under the authority of the Commissioner shall not be permitted or required to testify in a private civil action concerning confidential documents, materials, or other information subject to paragraph (8A) of this subsection.

(8C) To assist in the performance of the Commissioner's duties, the Commissioner:

(A) May share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to paragraph (8A) of this subsection, with other state, federal and international regulatory agencies; with the National Association of Insurance Commissioners, including its affiliates and subsidiaries; and with state, federal and international law enforcement authorities; provided, that the recipient agrees, and has the legal authority, to maintain the confidentiality and privileged status of the documents, materials, or other information;

(B) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information, from the National Association of Insurance Commissioners, including its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; or

(C) May enter into agreements governing the sharing and use of information consistent with paragraphs (8A), (8B), and (8C) of this subsection.

(8D) No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this section or of sharing as authorized in paragraph (8C) of this subsection. Nothing in this section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

(8E) The memorandum may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an act required by this section or by regulations promulgated hereunder.

(8F) The memorandum may be released by the Commissioner:

(A) With the written consent of the company; or

(B) To the American Academy of Actuaries, upon a request stating that the memorandum is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum.

(8G) If a portion of the memorandum is cited by the company in its marketing, is cited before a governmental agency other than a state insurance

department, or is released by the company to the news media, all portions of the memorandum shall be no longer confidential.

(9) A memorandum, in form and substance acceptable to the Mayor as specified by regulation, shall be prepared to support each actuarial opinion.

(10) If the insurance company fails to provide a supporting memorandum at the request of the Mayor within a period specified by regulation, or the Mayor determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the Mayor, the Mayor may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare any supporting memorandum required by the Mayor.

(11) Any memorandum in support of the opinion, and any other supporting material provided by the company to the Mayor, shall be kept confidential by the Mayor and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations promulgated hereunder. However, the memorandum or other material may otherwise be released by the Mayor with the written consent of the company, upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Mayor for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall no longer be confidential.

(b) *Actuarial analysis of reserves and assets supporting reserves.* —

(1) Every life insurance company, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by subsection (a)(1) of this section an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Mayor by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(2) The Mayor may provide by regulation for a transition period during which a life insurance company may establish any higher reserves that the qualified actuary deems necessary in order to render the opinion required by this section.

(Oct. 21, 1993, D.C. Law 10-50, § 2, 40 DCR 6117; Oct. 21, 2000, D.C. Law 13-191, § 7, 47 DCR 7311; June 11, 2004, D.C. Law 15-166, § 4(cc), 51 DCR 2817.)

Section references. — This section is referred to in § 31-3503.

Prior Codifications. — 1981 Ed., § 35-3801.

Effect of amendments. — D.C. Law 13-191 amending subsec. (a), added pars. (8A) to (8G).

D.C. Law 15-166, in par. (8A) of subsec. (a), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(cc) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 10-50. — D.C. Law 10-50, the “Life Insurance Actuarial Opinion of Reserves Act of 1993,” was introduced in Council and assigned Bill No. 10-133, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the

Mayor on August 4, 1993, it was assigned Act No. 10-95 and transmitted to both Houses of Congress for its review. D.C. Law 10-50 became effective on October 21, 1993.

Legislative history of Law 13-191. — Law 13-191, the “Insurer Confidentiality and Information Sharing Amendment Act of 2000,” was introduced in Council and assigned Bill No. 13-706, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 4, 2000, it was assigned Act No. 13-419 and transmitted to both Houses of Congress for its review. D.C. Law 13-191 became effective on October 21, 2000.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-50, the Life Insurance Actuarial Opinion of Reserves Act of 1993, see Mayor’s Order 94-54, March 7, 1994 (41 DCR 1433).

SUBTITLE VII. PROPERTY AND RELATED INSURANCE.

CHAPTER 50. INSURANCE PLACEMENT.

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31-5001. Purposes of chapter.	statements concerning insurability.
31-5002. Definitions.	
31-5003. Industry Placement Facility.	31-5008. Annual reports by Association; additional information.
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31-5005. Joint Underwriting Association; establishment; composition; plan of operation; participation by members; board of directors.	31-5010. Assessment of companies for reinsurance reimbursement fund; charge to insured to recover assessment.
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§ 31-5001. Purposes of chapter.

The purposes of this chapter are:

- (1) To assure stability in the property insurance market for property located in the District of Columbia;
- (2) To assure the availability of basic property insurance and homeowner's insurance as defined by this chapter;
- (3) To encourage maximum use and utilization, in obtaining basic property insurance and homeowner's insurance, of the normal insurance market provided by authorized insurers;
- (4) To provide for the equitable distribution among insurers of the responsibility for insuring qualified property in the District of Columbia for which insurance cannot be obtained through the normal insurance market and to authorize the establishment of a joint underwriting association in the District of Columbia to provide for insuring and reinsuring of basic property insurance and homeowner's insurance without regard to environmental hazards; and
- (5) To encourage the delivery of essential property insurance, and the homeowner's insurance that is provided by the Facility, at the most reasonable cost possible; provided, that insurance pricing by the Facility:
 - (A) Is actuarially self-supporting; and
 - (B) Does not actively compete with insurance pricing in the normal insurance market provided by authorized insurers.

(Aug. 1, 1968, 82 Stat. 567, Pub. L. 90-448, title XII, § 1202; Mar. 27, 2003, D.C. Law 14-251, § 2(a), 50 DCR 222.)

Prior Codifications. — 1981 Ed., § 35-1801.

1973 Ed., § 35-1701.

Effect of amendments. — D.C. Law 14-251 substituted "basic property insurance and homeowner's insurance" for "basic property insurance" throughout the section; in par. (3), substituted "maximum use and utilization" for "maximum use", and made a nonsubstantive

change; in par. (4), substituted "District of Columbia to provide for insuring and" for "District of Columbia to provide for", and made a nonsubstantive change; and added par. (5).

Legislative history of Law 14-251. — Law 14-251, the "Homeowner's Insurance Availability Amendment Act of 2002", was introduced in Council and assigned Bill No. 14-56, which was referred to the Committee on Consumer and

Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 2002, and December 3, 2002, respectively. Signed by the Mayor on December 24, 2002, it was as-

signed Act No. 14-548 and transmitted to both Houses of Congress for its review. D.C. Law 14-251 became effective on March 27, 2003.

CASE NOTES

ANALYSIS

Coverage.

Insolvent insurers.

Coverage.

Provision in District of Columbia fair access to insurance requirements plan that Superintendent of Insurance may not adopt procedures conflicting with minimum administrative procedures for the operation of the fair plans is not to be construed as preventing Superintendent from proceeding toward an expansion of insurance coverage as provided in the Act. D.C. Code § 35-1704(b). District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Insolvent insurers.

Creditor's agreement to release and extinguish its claim against debtors' surety and to accept in lieu thereof a deed of trust from debtors resulted in a novation, and its execution of the deed of trust and receipt of foreclosure funds excused surety from any further liability; thus, lacking a valid claim against surety, which subsequently became insolvent, creditor was not entitled to reimbursement from the District of Columbia Insurance Guaranty Association. D.C. Code §§ 35-1801, 35-1803, 35-1803(2, 3, 6), 35-1806, 35-1806(a)(1). Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

While a claimant under the District of Columbia Insurance Guaranty Act has no obligation to file a claim in a liquidation proceeding, it may not, under principles of equity, take actions which prejudice subrogation rights to which the District of Columbia Insurance

Guaranty Association would be entitled. D.C. Code §§ 35-1801 to 35-1817. Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

Where creditor's action of foreclosing on security on loan constituted a novation which invalidated its claim in liquidation proceeding of its insolvent debtor, and where creditor withdrew its claim in the liquidation proceeding after it had noticed an appeal from liquidator's recommendation that the claim be disallowed, any claim the District of Columbia Insurance Guaranty Association would have been entitled to pursue as subrogee of creditor under the District of Columbia Insurance Guaranty Act was likely prejudiced and, absent alternative basis for completely barring creditor's claim against the Association, its claim would have been barred only to extent that the Association's rights of subrogation were prejudiced, even if creditor had notified the Association of its intention to withdraw from the liquidation proceeding. D.C. Code §§ 35-1801, 35-1803, 35-1803(2, 3, 6) 35-1806, 35-1806(a)(1). Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

District of Columbia Insurance Guaranty Act, statute providing for creation of the District of Columbia Insurance Guaranty Association to facilitate reimbursement of District of Columbia residents for covered insurance claims when the insurer becomes insolvent, does not require a claimant to first establish validity of a claim in a liquidation proceeding. D.C. Code §§ 35-1801 to 35-1817. Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

§ 31-5002. Definitions.

As used in this chapter, unless the context otherwise requires:

(1) The term "Mayor" means the Mayor of the District of Columbia or his designated agent.

(2) The term "basic property insurance" means insurance against direct loss to property caused by perils as defined and limited in the standard fire policy and extended coverage endorsement thereon, as approved by the Commissioner.

(3) The term "environmental hazard" means any hazardous condition that

might give rise to loss under an insurance contract, but which is beyond the control of the property owner.

(3A) The term “homeowner’s insurance” means insurance for residential property that provides a combination of coverages, including fire, extended coverage, vandalism and malicious mischief, burglary, theft, and personal liability. The term shall include a policy of insurance which is limited to basic market value, repair cost, or actual cash value contracts for owner-occupants of one-to-four-family dwellings as approved by the Commissioner.

(4) The term “inspection bureau” means any rating bureau or other organization designated by the Mayor to perform inspections to determine the condition of the properties for which basic property insurance or homeowner’s insurance is sought.

(5) The terms “Industry Placement Facility” and “Facility” mean the facility consisting of all insurers licensed to write and engaged in writing basic property insurance or homeowner’s insurance (including homeowners and commercial multiperil policies) within the District of Columbia to assist agents, brokers, and applicants in securing basic property insurance or homeowner’s insurance.

(6) The term “premiums written” means gross direct premiums charged with respect to property in the District of Columbia on all policies of basic property insurance and the basic property insurance premium components of all multiperil policies, less all premiums and dividends returned, paid, or credited to policyholders or the unused or unabsorbed portions of premiums deposits.

(7) The term “property owner” means any person having an insurable interest in real, personal, or mixed real and personal property.

(Aug. 1, 1968, 82 Stat. 568, Pub. L. 90-448, title XII, § 1203; Mar. 27, 2003, D.C. Law 14-251, § 2(b), 50 DCR 222.)

Prior Codifications. — 1981 Ed., § 35-1802.

1973 Ed., § 35-1702.

Effect of amendments. — D.C. Law 14-251 rewrote par. (2); added par. (3A); and substituted “basic property insurance or homeowner’s insurance” for “basic property insurance” in pars. (4) and (5).

Legislative history of Law 14-251. — For Law 14-251, see notes following § 31-5001.

Editor’s notes. — Delegation of functions: Reorganization Order No. 43, as amended August 12, 1968, delegated to the Superintendent of Insurance the functions vested in the Mayor by this chapter.

Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance

headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were as-

sumed by the Commissioner of Insurance and Securities and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorgani-

zation Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

Crime lines.

District of Columbia Superintendent of Insurance had statutory authority to issue order including "crime lines" within definition of basic property insurance under the Insurance Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the national insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including "crime lines" within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. *District of Columbia Ins. Placement Facility v. Washington*, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

§ 31-5003. Industry Placement Facility.

(a) Within 30 days after August 1, 1968, all insurers licensed to write and engaged in writing in the District of Columbia, on a direct basis, basic property insurance or any component thereof in multiperil policies shall establish an Industry Placement Facility. The Facility shall formulate and administer a program, subject to disapproval by the Mayor in whole or in part, to seek the equitable apportionment among such insurers of basic property insurance and homeowner's insurance which may be afforded applicants in the District of Columbia whose property is insurable in accordance with reasonable underwriting standards and who individually or through their insurance agent or broker request the aid of the Facility to procure such insurance. The Facility shall seek to place insurance with 1 or more participating companies up to the full insurable value of the risk, if requested, except to the extent that deductibles, percentage participation clauses, and other underwriting devices are employed to meet special problems of insurability.

(b) The Facility may, subject to the approval of the Commissioner, provide as part of its program for the equitable distribution of commercial risks and dwelling risks among insurers. Such distribution of risks may be implemented through assignment of policies to one or more participating companies or through joint underwriting of risks as provided by § 31-5005.

(c) Each insurer licensed to write and engaged in writing in the District of Columbia, on a direct basis, basic property insurance or any component thereof in multiperil policies shall participate in the Industry Placement Facility

program in accordance with the established rules of the program as a condition of its authority to transact such kinds of insurance in the District of Columbia, except that, in lieu of revoking or suspending the certificate of authority of any company for any failure to comply with any of the established rules of the program, the Mayor may subject such company to a penalty of not more than \$200 for each such failure to so comply when in his judgment he finds that the public interest would be best served by the continued operation of the company in the District of Columbia.

(Aug. 1, 1968, 82 Stat. 568, Pub. L. 90-448, title XII, § 1204; Mar. 27, 2003, D.C. Law 14-251, § 2(c), 50 DCR 222.)

Prior Codifications. — 1981 Ed., § 35-1803.

1973 Ed., § 35-1703.

Effect of amendments. — D.C. Law 14-251, in subsec. (a), substituted “to seek the equitable apportionment among such insurers of basic property insurance and homeowner’s insurance which may be afforded applicants” for “to seek the equitable apportionment amount such insurers of basic property insurance which may be afforded applicants”; and rewrote subsec. (b) which had read as follows: “(b) The Facility may, subject to the approval of the Mayor, provide as part of its program for the equitable distribution of commercial risks and dwelling risks among insurers.”

Legislative history of Law 14-251. — For Law 14-251, see notes following § 31-5001.

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Coverage.
Crime lines.
Insolvent insurers.

Coverage.

Provision in District of Columbia fair access to insurance requirements plan that Superintendent of Insurance may not adopt procedures conflicting with minimum administrative procedures for the operation of the fair plans is not to be construed as preventing Superintendent from proceeding toward an expansion of insurance coverage as provided in the Act. D.C. Code § 35-1704(b). District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Crime lines.

District of Columbia Superintendent of Insurance had statutory authority to issue order including “crime lines” within definition of basic property insurance under the Insurance

Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the national insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including “crime lines” within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as

amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Insolvent insurers.

Creditor's agreement to release and extinguish its claim against debtors' surety and to accept in lieu thereof a deed of trust from debtors resulted in a novation, and its execution of the deed of trust and receipt of foreclosure funds excused surety from any further liability; thus, lacking a valid claim against surety, which subsequently became insolvent, creditor was not entitled to reimbursement from the District of Columbia Insurance Guaranty Association. D.C. Code §§ 35-1801, 35-1803, 35-1803(2, 3, 6), 35-1806, 35-1806(a)(1). Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

Where creditor's action of foreclosing on security on loan constituted a novation which

invalidated its claim in liquidation proceeding of its insolvent debtor, and where creditor withdrew its claim in the liquidation proceeding after it had noticed an appeal from liquidator's recommendation that the claim be disallowed, any claim the District of Columbia Insurance Guaranty Association would have been entitled to pursue as subrogee of creditor under the District of Columbia Insurance Guaranty Act was likely prejudiced and, absent alternative basis for completely barring creditor's claim against the Association, its claim would have been barred only to extent that the Association's rights of subrogation were prejudiced, even if creditor had notified the Association of its intention to withdraw from the liquidation proceeding. D.C. Code §§ 35-1801, 35-1803, 35-1803(2, 3, 6) 35-1806, 35-1806(a)(1). Hemisphere Nat'l Bank v. District of Columbia Ins. Guaranty Asso., 412 A.2d 31, 1980 D.C. App. LEXIS 257 (1980).

§ 31-5004. Rules and regulations.

(a) The Industry Placement Facility shall on its own motion, or within 30 days after a request by the Mayor, submit to the Mayor such proposed rules and regulations applicable to insurers, agents, and brokers deemed necessary to assure all property owners fair access to basic property insurance through the normal insurance markets, including rules and regulations concerning:

(1) The manner and scope of inspections of risk by an inspection bureau;

(2) The preparation and filing of inspection reports and reports on actions taken in connection with inspected risks, and summaries thereof; and

(3) The operation of the Facility, including rules and regulations concerning:

(A) The basic property insurance coverages to be provided through the Facility;

(A-i) The homeowner's insurance coverages to be provided through the Facility; provided, that these coverages shall not be less than homeowner's insurance;

(B) The reasonable effort to obtain insurance in the normal commercial market required of an applicant before recourse to the Facility; and

(C) The appeals procedure within the Facility for any applicant for insurance regarding any ruling, action, or decision by or on behalf of the Facility.

(b) The Mayor may adopt such of the rules and regulations submitted pursuant to subsection (a) of this section as he approves. If the Mayor disapproves any proposed rule or regulation submitted, he shall state the reasons for so doing, and he shall require the Facility to submit a revision thereof within such time as he may designate, but not less than 10 days. During such designated time, the Mayor and the Facility shall consult regarding any such disapproved rule or regulation. If the Facility fails to submit a proposed rule or regulation, or revision thereof, within the designated

time, or if a revised rule or regulation is unacceptable to the Mayor, the Mayor may make such rules and regulations covering the proposed general subject matter as he shall deem necessary to carry out the purposes of this chapter. Any rule or regulation adopted or made under this section shall be consistent with the requirements of part A of title XII of the National Housing Act.

(Aug. 1, 1968, 82 Stat. 569, Pub. L. 90-448, title XII, § 1205; Mar. 27, 2003, D.C. Law 14-251, § 2(d), 50 DCR 222.)

Prior Codifications. — 1981 Ed., § 35-1804.

1973 Ed., § 35-1704.

Effect of amendments. — D.C. Law 14-251 added par. (A-i) to subsec. (a)(3).

Legislative history of Law 14-251. — For Law 14-251, see notes following § 31-5001.

References in text. — “Part A of title XII of the National Housing Act,” referred to at the end of subsection (b), consists of §§ 1211 to 1214, as added by § 1103 of the Act of August 1, 1968, 82 Stat. 558, Pub. L. 90-448, codified at 12 U.S.C. §§ 1749bbb-7 to 1749bbb-10.

Editor's notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See His-

torical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Coverage.

Crime lines.

Geographic discrimination.

Coverage.

Provision in District of Columbia fair access to insurance requirements plan that Superintendent of Insurance may not adopt procedures conflicting with minimum administrative procedures for the operation of the fair plans is not to be construed as preventing Superintendent from proceeding toward an expansion of insurance coverage as provided in the Act. D.C. Code § 35-1704(b). District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Crime lines.

District of Columbia Superintendent of Insurance had statutory authority to issue order including “crime lines” within definition of basic property insurance under the Insurance Placement Act even though the Secretary of Housing and Urban Development had not incorporated those lines into the definition of essential property insurance under the national insurance development program, but the authority is qualified by substantive constitutional requirements of due process. D.C. Code

§§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3. District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Order of District of Columbia Superintendent of Insurance including “crime lines” within definition of basic property insurance under Insurance Placement Act denied due process where it was issued without giving insurance placement facility, which was established to implement federal program of establishing and effectuating plans to assure fair access to insurance requirements, notice or opportunity for hearing. D.C. Code §§ 35-1701 et seq., 35-1703, 35-1704(b); National Housing Act, § 1211 as amended 12 U.S.C. § 1749bbb-3; U.S. Const. Amend. 14. District of Columbia Ins. Placement Facility v. Washington, 269 A.2d 45, 1970 D.C. App. LEXIS 338 (App. 1970).

Geographic discrimination.

Regulation prohibiting auto, fire or casualty insurer from considering geographical location in determining whether to insure or continue to insure a risk in the District of Columbia except in cases of overconcentration of liability in a single high risk area and regulation prohibiting cancellation of auto, fire and casualty policies only for specified reasons are within the police

power accorded to the District of Columbia by congressional enactment. D.C. Code § 1-226. *Firemen's Ins. Co. v. Washington*, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

District of Columbia regulation generally precluding the insurance company from considering geographic location in determining whether to insure or continue to insure auto, fire and casualty risks in district and prohibiting cancellation of those policies for other than specified conditions do not conflict with specific provisions of the District of Columbia Insurance Code or the Automobile Insurance Plan and were not preempted thereby; with respect to basic property insurance regulation prohibiting geographic discrimination did conflict with and was preempted by the District of Columbia Insurance Placement Act. D.C. Code §§ 1-226, 35-1503(c), 35-1505, 35-1505(d), 35-1701 et seq.; National Housing Act, § 1201, 12 U.S.C. § 1749bbb. *Firemen's Ins. Co. v. Washington*, 483 F.2d 1323, 1973 U.S. App. LEXIS 8554 (C.A.D.C. 1973).

District of Columbia city council did not have authority under either its police power or the

Insurance Code to pass insurance regulations designed to prohibit geographic discrimination and arbitrary cancellation of policies within the District. Reorganization Plan No. 3 of 1967, §§ 402(4), 406, D.C. Code Tit. 1, Appendix I; D.C. Code §§ 1-226, 35-102, 35-1701 to 35-1711. *Firemen's Ins. Co. v. Washington*, 333 F. Supp. 951, 1971 U.S. Dist. LEXIS 11190 (1971), affirmed in part and reversed in part by 483 F.2d 1323, 157 U.S. App. D.C. 320, 1973 U.S. App. LEXIS 8554 (1973).

Where Congress provided for the equitable distribution of responsibility for insuring qualified property within the District of Columbia for which insurance could not be obtained through the normal market by passing the Insurance Placement Act, the city council of the District could not thereafter regulate the same type of high risk coverage by passing regulation designed to prohibit geographic discrimination. D.C. Code § 35-1704. *Firemen's Ins. Co. v. Washington*, 333 F. Supp. 951, 1971 U.S. Dist. LEXIS 11190 (1971), affirmed in part and reversed in part by 483 F.2d 1323, 157 U.S. App. D.C. 320, 1973 U.S. App. LEXIS 8554 (1973).

§ 31-5005. Joint Underwriting Association; establishment; composition; plan of operation; participation by members; board of directors.

(a) The Mayor is authorized to establish by order a Joint Underwriting Association if he finds, after notice and hearing, that such Association is necessary to carry out the purposes of this chapter. Such Joint Underwriting Association shall consist of all insurers licensed to write and engaged in writing in the District of Columbia, on a direct basis, such basic property insurance as may be designated by the Mayor or any component thereof in multiperil policies.

(b) Every such insurer shall be and remain a member of the Association and shall comply with all requirements of membership as a condition of its authority to transact such kinds of insurance in the District of Columbia, except that in lieu of revoking or suspending the certificate of authority of any company for any failure to comply with any of the requirements of membership, the Mayor may subject such company to a penalty of not more than \$200 for each such failure to so comply when in his judgment he finds that the public interest would be best served by the continued operation of the company in the District of Columbia.

(c)(1) Within 60 days following the effective date of the order of the Mayor under this section the Association shall submit to him a proposed plan of operation, consistent with the provisions of this chapter, which shall provide for economical, fair, and nondiscriminatory administration of the Association and for the prompt and efficient provision of insurance or reinsurance, without regard to environmental hazards, for such basic property insurance and

homeowner's insurance as may be designated by the Mayor. The plan of operation shall include provisions for:

(A) Preliminary assessment of all members for initial expenses necessary to commence operations;

(B) Establishment of necessary facilities;

(C) Management and operation of the Association;

(D) Assessment of members to defray losses and expenses;

(E) Commission arrangements;

(F) Reasonable underwriting standards and ratemaking;

(G) Assumption and cessation of insurance and of reinsurance;

(G-i) Immediate binding of eligible homeowner's risks;

(G-ii) Encouragement of agents, brokers, and applicants to transfer insurance coverage provided by the Association, through either insurance or reinsurance, to the normal insurance market provided by authorized insurers; and

(H) Such other matters as the Mayor may designate.

(2) The plan of operation shall not take effect until approved by the Mayor. If the Mayor disapproves the proposed plan of operation (or any part thereof), he shall state the reasons for so doing, and the Association shall within 30 days thereafter submit for his review an appropriately revised plan of operation. During such time, the Mayor and the Association shall consult regarding the disapproved plan or part thereof. If the Association fails to submit a revised plan of operation, or if the revised plan so submitted is unacceptable to the Mayor, the Mayor shall promulgate a plan of operation.

(3) The Association may, on its own initiative, amend such plan, subject to approval by the Mayor, and shall amend such plan at the direction of the Mayor if he finds such action is necessary to carry out the purposes of this chapter.

(d) All members of the Association shall participate in its writings, expenses, profits, and losses, or in such categories thereof as may be separately established by the Association, subject to approval by the Mayor, in the proportion that the premiums written by each such member during the preceding calendar year bear to the aggregate premiums written in the District of Columbia by all members of the Association, or in accordance with such other formula as the Association may devise with the approval of the Mayor. Such participation by each insurer in the Association shall be determined annually on the basis of such premiums written during the preceding calendar year as disclosed in the annual statements and other reports filed by the insurer with the Mayor.

(e) The Association shall be governed by a board of 11 directors, elected annually by cumulative voting by the members of the Association, whose votes in such election shall be weighted in accordance with the proportionate amount of each member's net direct premiums written in the District of Columbia during the preceding calendar year. The 1st board shall be elected at a meeting of the members or their authorized representatives, which shall be held within 30 days after the effective date of the order under this section establishing the Association, at a time and place designated by the Mayor.

(Aug. 1, 1968, 82 Stat. 569, Pub. L. 90-448, title XII, § 1206; Mar. 27, 2003, D.C. Law 14-251, § 2(e), 50 DCR 222.)

Prior Codifications. — 1981 Ed., § 35-1805.

1973 Ed., § 35-1705.

Effect of amendments. — D.C. Law 14-251, in subsec. (c)(1), substituted “efficient provision of insurance or” for “efficient provision of” and substituted “basic property insurance and homeowner’s insurance” for “basic property insurance”; in par. (F) of subsec. (c)(1), substituted “Reasonable underwriting standards and ratemaking” for “Reasonable underwriting standards”; rewrote par. (G) of subsec. (c)(1); and added pars. (G-i) and (G-ii) to subsec. (c)(1). Prior to amendment, par. (G) of subsec. (c)(1) had read as follows: “(G) Assumption and cessation of reinsurance; and”

Legislative history of Law 14-251. — For Law 14-251, see notes following § 31-5001.

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5006. Supervision and regulation of operations by Mayor.

The operation of any inspection bureau, the Industry Placement Facility, and the Joint Underwriting Association shall at all times be subject to the supervision and regulation of the Mayor. The Mayor shall have the power of visitation of and examination into such operations and free access to all the books, records, files, papers, and documents that relate to such operations, may summon and qualify witnesses under oath, and may examine directors, officers, agents, employees or any other person having knowledge of such operations.

(Aug. 1, 1968, 82 Stat. 571, Pub. L. 90-448, title XII, § 1207.)

Prior Codifications. — 1981 Ed., § 35-1806.

1973 Ed., § 35-1706.

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the Dis-

trict of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5007. Immunity from liability in regard to statements concerning insurability.

There shall be no liability on the part of, and no cause of action of any nature

shall arise against, insurers, any inspection bureau, the Industry Placement Facility, the Joint Underwriting Association, the agents or employees of such bureau, Facility, or Association, or any officer or employee of the District of Columbia, for any statements made in good faith by them concerning the insurability of property: (1) In any reports or other communications; (2) at the time of the hearings conducted in connection therewith; or (3) in the findings with respect thereto required by the provisions of this chapter. The reports and communications of any inspection bureau, the Industry Placement Facility, and the Joint Underwriting Association with respect to individual properties shall not be open to inspection by, or otherwise available to, the public.

(Aug. 1, 1968, 82 Stat. 571, Pub. L. 90-448, title XII, § 1208.)

Prior Codifications. — 1981 Ed., § 35-1807. 1973 Ed., § 35-1707.

§ 31-5008. Annual reports by Association; additional information.

The Joint Underwriting Association shall file with the Mayor, annually on or before the 1st day of March, a statement which shall contain information with respect to its transactions, condition, operations, and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed by the Mayor and shall be in such form as is approved by him. The Mayor may at any time require the Association to furnish him with additional information with respect to its transactions, condition, or any matter connected therewith which he considers to be material and which will assist him in evaluating the scope, operation, and experience of the Association.

(Aug. 1, 1968, 82 Stat. 571, Pub. L. 90-448, title XII, § 1209.)

Prior Codifications. — 1981 Ed., § 35-1808. 1973 Ed., § 35-1708.

Editor's notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the Dis-

trict of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5009. Administrative appeals; judicial review.

(a) Any applicant for insurance and any affected insurer may appeal to the Mayor within 90 days after any final ruling, action, or decision by or on behalf of any inspection bureau, the Industry Placement Facility, or the Joint Underwriting Association, following exhaustion of remedies available within such bureau, Facility, or Association.

(b) All final orders or decisions of the Mayor made under this chapter shall be subject to review by the District of Columbia Court of Appeals under the District of Columbia Administrative Procedure Act.

(Aug. 1, 1968, 82 Stat. 571, Pub. L. 90-448, title XII, § 1210; July 29, 1970, 84 Stat. 583, Pub. L. 91-358, title I, § 163(d).)

Prior Codifications. — 1981 Ed., § 35-1809.

1973 Ed., § 35-1709.

References in text. — The “District of Columbia Administrative Procedure Act,” referred to in Subsection (b) of this section, in the Act of October 21, 1968, 82 Stat. 1203, Pub. L. 90-614, codified as subchapter I of Chapter 15 of Title 1 (subchapter I of Chapter 5 of Title 2, 2001 Ed.).

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section

originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5010. Assessment of companies for reinsurance reimbursement fund; charge to insured to recover assessment.

(a) In order to carry out the purposes of this chapter and to make available to insurers who participate hereunder the reinsurance afforded under part B of title XII of the National Housing Act [12 U.S.C. § 1749bbb-7 et seq.] against losses to property resulting from riots or civil disorders, the Mayor is authorized to assess each insurance company authorized to do business in the District of Columbia an amount, in the proportion that the premiums earned by each such company in the District of Columbia, on lines reinsured in the District of Columbia by the Secretary of Housing and Urban Development, during the preceding calendar year bear to the aggregate premiums earned on those lines in the District of Columbia by all insurance companies, sufficient to provide a fund to reimburse the Secretary of Housing and Urban Development in the manner set forth in § 1223(a)(1) of such Part B [12 U.S.C. § 1749bbb-9]. Such fund may be added to or such fund may be created by moneys appropriated therefor by the Congress.

(b) Insurers shall add to the premium rate an amount, to be approved by the Mayor, sufficient to recover, within not more than 3 years, any amounts assessed under subsection (a) of this section during the preceding calendar year. Such amount shall be a separate charge to the insured in addition to the premium to be paid and shall be reflected as such in the policy of insurance. No commission shall be paid thereon to any agent or broker producing or selling the policy of insurance wherein such amount is added.

(Aug. 1, 1968, 82 Stat. 572, Pub. L. 90-448, title XII, § 1211.)

Prior Codifications. — 1981 Ed., § 35-1810.

1973 Ed., § 35-1710.

References in text. — “Part B of title XII of the National Housing Act,” referred to in subsection (a) of this section, consists of §§ 1221 to 1224, as added by § 1103 of the Act of August 1, 1968, 82 Stat. 560, Pub. L. 90-448, codified at 12 U.S.C. §§ 1749bbb-7 to 1749bbb-10.

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section

originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the District of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5011. Delegation of functions by Mayor.

The Mayor is authorized to delegate any of the functions vested in him by this chapter.

(Aug. 1, 1968, 82 Stat. 572, Pub. L. 90-448, title XII, § 1212.)

Prior Codifications. — 1981 Ed., § 35-1811.

1973 Ed., § 35-1711.

Editor’s notes. — Delegation of functions: See Historical and Statutory Notes following § 31-5002.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5002.

Change in Government. — This section originated at a time when local government powers were delegated to the District of Columbia Council and to a Commissioner of the Dis-

trict of Columbia. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CHAPTER 50A. TITLE INSURANCE INSURERS.

Sec.	Sec.
31-5031.01. Definitions.	the services of title insurance producers.
31-5031.02. Licensing needed to transact business.	31-5031.14. Conditions for maintaining escrow and indemnity deposit accounts.
31-5031.03. Authorized activities of title insurers.	31-5031.15. Prohibition of rebate and fee splitting.
31-5031.04. Limitations on powers.	31-5031.16. Favored agent of title insurer.
31-5031.05. Minimum capital and surplus requirements.	31-5031.17. Premium rate filings and standards.
31-5031.06. Single risk limit.	31-5031.18. Form filing.
31-5031.07. Admitted asset standards.	31-5031.19. Filing by rating bureaus.
31-5031.08. Reserves.	31-5031.20. Record retention requirements.
31-5031.09. Liquidation, dissolution, or insolvency.	31-5031.21. Penalties and liabilities.
31-5031.10. Restrictions on dividends.	31-5031.22. Violations of Real Estate Settlement Procedures Act ("RESPA").
31-5031.11. Diversification requirement.	31-5031.23. Rules; orders.
31-5031.12. Direct operations and policyholder treatment.	31-5031.24. Applicability; construction.
31-5031.13. Duties of title insurers utilizing	

§ 31-5031.01. Definitions.

For the purposes of this chapter, the term:

(1) "Abstract of title" or "abstract" means a written history, synopsis, or summary of the recorded instruments affecting the title to real property.

(2) "Affiliate" means, with respect to a person, another person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(3) "Aggrieved party" means a lender, title insurer, consumer, or the District of Columbia, who shall have suffered economic harm as a result of matters insured under any fidelity coverage required under this chapter.

(4) "Attorney" means a person who holds a license to practice law in the District of Columbia.

(5) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking, or the Commissioner's representatives, or the commissioner, director, or superintendent of insurance in any other state.

(6) "Direct operations" means that portion of a title insurer's operations that is attributable to business written or conducted directly by an employee of:

(A) The title insurer;

(B) A title insurance producer owned by:

(i) The title insurer;

(ii) A parent entity owning the title insurer;

(iii) A holding entity owning the title insurer; or

(iv) A subsidiary of a parent or holding entity owning a title insurer.

(7) "Escrow" means written instruments, money, or other items deposited by one party with a depository, escrow agent, or escrowee for delivery to another party upon the performance of a specified condition or the happening of a certain event.

(8) "Escrow Officer" means a person who maintains an escrow or indemnified deposit account.

(9) “Escrow, settlement, or closing fee” means the consideration for supervising or handling the actual execution, delivery, or recording of transfer and lien documents and for disbursing funds.

(10) “Fire and Casualty Act” means Chapter 25 of this title [§ 31-2501.01 et seq.].

(11) “Foreign title insurer” means any title insurer incorporated or organized under the laws of any other state of the United States or any other jurisdiction of the United States.

(12) “Indemnity” or “indemnity deposit” means funds or other property received by the title insurer as collateral to secure an indemnitor’s obligation under an indemnity agreement pursuant to which the insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

(13) “IRLA” means Chapter 13 of this title [§ 31-1301 et seq.].

(14) “Net retained liability” means the total liability retained by a title insurer for a single risk, after taking into account any ceded liability and collateral, acceptable to the Commissioner, maintained by the insurer.

(15) “Non-U.S. title insurer” means any title insurer incorporated or organized under the laws of any foreign nation or any province or territory.

(16) “Person” means an individual, partnership, limited liability company, association, cooperative, corporation, trust, or other legal entity.

(17) “Personal property” means stock ownership in a cooperative housing association.

(18) “Qualified financial institution” means an institution that is:

(A) Organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers;

(B) Regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies;

(C) Insured by the appropriate federal entity; and

(D) Qualified under any additional rules established by the Commissioner.

(19) “Referral source” means any person, including an officer, director, or owner of more than 5% or more of the equity or capital of any person engaged in the District in the trade, business, occupation, or profession of:

(A) Buying or selling interests in real property;

(B) Making loans secured by interests in real property; or

(C) Acting as broker, agent, representative, or attorney of a person who buys or sells any interest in real property or who lends or borrows money with the interest as security.

(20) “Residential property” means real property located in the District of Columbia with one to 4 residential dwelling units in the same or appurtenant structure.

(21) “Subsidiary” means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(22) “Title insurance business” or “business of title insurance” means:

(A) Issuing as an insurer, or offering to issue as an insurer, a title insurance policy;

(B) Engaging in, or proposing to engage in, any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

- (i) Soliciting or negotiating the issuance of a title insurance policy;
- (ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases, and for all liens or charges affecting the same;
- (iii) Executing title insurance policies;
- (iv) Effecting contracts of reinsurance; or
- (v) Abstracting, searching, or examining titles;

(C) Guaranteeing, warranting, or insuring searches or examinations of title to real property or any interest in real property;

(D) Guaranteeing or warranting the status of title as to ownership of or liens on real property or personal property by any person other than the principals to the transaction;

(E) Doing, or holding oneself out to do, business substantially equivalent to any of the activities listed in this paragraph in a manner designed to evade the provisions of this chapter; or

(F) Matters insuring the correctness or marketability of title.

(23) "Title insurance commitment" means a preliminary report, commitment, or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions, and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy.

(24) "Title insurance policy" or "policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or any interest in real or personal property, against loss or damage arising from any or all of the following conditions existing on or before the policy date and not excepted or excluded:

- (A) Defects in, or liens or encumbrances on, the insured title;
- (B) Unmarketability of the insured title;
- (C) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the stated property;
- (D) Lack of legal right of access to the land;
- (E) Unenforceability of rights in title to the land and other matters affecting the title to, or the right to the use and enjoyment of, the property; or
- (F) Matters insuring the correctness or marketability of title.

(25)(A) "Title insurance producer" or "producer" means a person who is authorized to perform, on behalf of a title insurer, the following acts in conjunction with the issuance of a title insurance commitment or policy covering residential or personal property situated in the District of Columbia:

- (i) Determining insurability and issuing title insurance commitments or policies, or both, based upon the performance or review of a search or abstract of title; and
 - (ii) Soliciting or negotiating title insurance business.
- (B) The term "title insurance producer" or "producer" shall not include:

(i) A financial institution (and its employees) that does not solicit, procure, or negotiate title insurance contracts for compensation or conduct title insurance business;

(ii) An employee of an abstracting company;

(iii) A person whose activities in the District are limited to advertising, without the intent to solicit insurance in the District, through communications in printed publications or other forms of electronic mass media; provided, that the person does not sell, solicit, or negotiate insurance that would insure risks of persons residing in or located in, or activities to be performed in, the District;

(iv) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries of the employer; provided, that the employee does not sell, solicit, or negotiate insurance, or receive a commission; or

(v) An employee of a title insurer; provided, that the employee's activities are not focused on transactions in the District of Columbia, his or her primary responsibilities cover multiple states, and his or her involvement in transactions is to coordinate with title insurance producers licensed in the District of Columbia who conduct title insurance business.

(26) "Title insurer" or "insurer" means a company organized under laws of the District of Columbia for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in the District of Columbia to transact the business of title insurance.

(27) "Title plant" means a set of records consisting of documents, maps, surveys, or entries affecting title to real property or any interest in or encumbrance on the property, which have been filed or recorded in the jurisdiction for which the title plant is established or maintained.

(28) "Underwrite" means to accept or reject, or have the authority to accept or reject, risk on behalf of a title insurer.

(Sept. 24, 2010, D.C. Law 18-223, § 2142, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2142 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — Law 18-223, the "Fiscal Year 2011 Budget Support Act of 2010", was introduced in Council and assigned Bill No. 18-731, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on May

26, 2010, and June 15, 2010, respectively. Signed by the Mayor on July 2, 2010, it was assigned Act No. 18-462 and transmitted to both Houses of Congress for its review. D.C. Law 18-223 became effective on September 24, 2010.

Short title. — Short title: Section 2141 of D.C. Law 18-223 provided that subtitle M of title II of the act may be cited as the "Title Insurance Insurer Act of 2010".

§ 31-5031.02. Licensing needed to transact business.

No person, other than a domestic, foreign, or non-U.S. title insurer organized on the stock plan and licensed under Chapter 25 of this title [§ 31-2501.01 et seq.], shall issue a title insurance policy or otherwise transact the business of title insurance in the District.

(Sept. 24, 2010, D.C. Law 18-223, § 2143, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2143 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.03. Authorized activities of title insurers.

Subject to the exceptions and restrictions contained in this chapter, a title insurer may do any of the following:

- (1) Engage in the business of writing title insurance directly or through title insurance producers appointed for the purpose of issuing policies of title insurance;
- (2) Reinsure title insurance policies;
- (3) Unless prohibited by the Commissioner, perform ancillary activities, including examining titles to real property and any interest in real or personal property and procuring and furnishing related information and information about relevant personal property, when not in contemplation of, or in conjunction with, the issuance of a title insurance policy; and
- (4) Maintain or perform escrow, indemnity, or settlement services.

(Sept. 24, 2010, D.C. Law 18-223, § 2144, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2144 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.04. Limitations on powers.

(a) An insurer that transacts any class, type, or kind of business other than title insurance business shall not be eligible for the issuance or renewal of a license to transact the business of title insurance in the District of Columbia and shall not transact title insurance business.

(b) A title insurer shall not engage in the business of guaranteeing payment of the principal of, or the interest on, bonds or mortgages.

(c)(1) Notwithstanding subsection (a) of this section, and to the extent such coverage is lawful within the District, a title insurer may issue closing or settlement protection to a proposed insured upon request if the title insurer issues a preliminary report, binder, or title insurance policy. The closing or settlement protection shall conform to the terms of coverage and form of instrument as required by the Commissioner and may indemnify a proposed insured solely against loss of settlement funds only because of the following acts of a title insurer's named title insurance producer:

(A) Theft of settlement funds in connection with the closing to the extent that the theft relates to the status of the title to that interest in land or to the validity, enforceability, and priority of the lien of the mortgage on that interest in land; and

(B) Failure to comply with the written closing instructions by the proposed insured when agreed to by the title insurance producer, to the extent that they relate to the status of the title to that interest in land or the validity, enforceability, and priority of the lien of the mortgage on that interest in land.

(2) The Commissioner may promulgate by rule pursuant to § 31-5031.23, or approve, a required charge for providing the coverage.

(3) The charge for issuance of a closing or settlement protection letter in a residential property transaction indemnifying a seller of an interest in real property, a refinancing borrower, or a buyer who does not purchase title insurance shall be not less than \$50.

(4) Except as provided under this chapter, a title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement, or closing services.

(5) The form of closing protection letter used by a title insurer and rates shall be filed with the Commissioner as provided by § 31-5031.18(b)(3).

(Sept. 24, 2010, D.C. Law 18-223, § 2145, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2145 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.05. Minimum capital and surplus requirements.

Before being licensed to do an insurance business in the District, a title insurer shall establish and maintain a minimum paid-in capital of not less than \$500,000 and paid-in initial surplus of at least \$500,000, for a total minimum capital and surplus total of at least \$1 million.

(Sept. 24, 2010, D.C. Law 18-223, § 2146, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2146 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.06. Single risk limit.

(a) The net retained liability of a title insurer for a single risk in regard to property, whether assumed directly or as reinsurance, shall not exceed the aggregate of 50% of surplus as regards policyholders, plus the statutory premium reserve less the company's investment in title plants, all as shown in the most recent annual statement of the insurer on file with the Commissioner.

(b) For the purposes of this chapter:

(1) A single risk shall be the insured amount of any title insurance policy; provided, that, if 2 or more title insurance policies are issued simultaneously covering different estates in the same real property, a single risk shall be the sum of the insured amounts of all the title insurance policies.

(2) A policy under which a claim payment reduces the amount of insurance under one or more other title insurance policies shall be included in computing the single risk sum only to the extent that its amount exceeds the aggregate amount of the policy or policies whose amount of insurance is reduced.

(Sept. 24, 2010, D.C. Law 18-223, § 2147, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2147 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.07. Admitted asset standards.

In determining the financial condition of a domestic title insurer doing business under this chapter, the general investment provisions of the Chapter 13A of this title [§ 31-1371.01 et seq.], shall apply; provided, that:

(1) An investment in a title plant or plants in an amount equal to the actual cost shall be allowed as an admitted asset for title insurers; and

(2) The aggregate amount of the investment shall not exceed the lesser of 20% of admitted assets or 40% of surplus to policyholders, as shown on the most recent annual statement of the title insurer on file with the Commissioner.

(Sept. 24, 2010, D.C. Law 18-223, § 2148, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2148 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.08. Reserves.

(a) In determining the financial condition of a title insurer doing business under this chapter, the general provisions of the acts relating to insurance which are codified in this title requiring the establishment of reserves sufficient to cover all known and unknown liabilities, including allocated and unallocated loss adjustment expense, shall apply; provided, that a domestic title insurer shall establish and maintain:

(1) A known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title, and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable, and for which the insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or indemnity depositor; and

(2) A statutory or unearned premium reserve consisting of:

(A) The amount of statutory or unearned premium reserve required by the laws of the domiciliary state of the insurer if the insurer is a foreign or non-U.S. title insurer; or

(B) If the insurer is a domestic insurer of the District of Columbia:

(i) The amount of the statutory or unearned premium or reinsurance reserve on January 1, 2011, which balance shall be released in accordance with the law in effect at the time such sums were added to the reserve; and

(ii) Out of total charges for policies of title insurance written or assumed commencing with January 1, 2011, and until December 31, 2011, a title insurer shall add to, and set aside in, the reserve an amount equal to 8%

of the sum of the following items set forth in the title insurer's most recent annual statement on file with the Commissioner:

- (I) Direct premiums written;
- (II) Escrow and settlement service fees;
- (III) Other title fees and service charges, including fees for closing protection letters; and
- (IV) Premiums for reinsurance assumed, less premiums for reinsurance ceded during year.

(b) Additions to the reserve after January 1, 2011, shall be, made out of total charges for title insurance policies and guarantees written, equal to the sum of the following items, as set forth in the title insurer's most recent annual statement on file with the Commissioner:

(1) For each title insurance policy on a single risk written or assumed after January 1, 2011, \$0.36 per \$1,000 of net retained liability for policies under \$500,000 and \$0.16 per \$1,000 of net retained liability for policies of \$500,000 or greater; and

(2) Eight percent of escrow, settlement, and closing fees collected in contemplation of the issuance of title insurance policies or guarantees.

(c) The aggregate of the amounts set aside in the reserve in any calendar year pursuant to subsections (a)(2)(B)(ii) and (b) of this section shall be released from the reserve and restored to net profits over a period of 20 years pursuant to the following formula:

(1) Thirty-five percent of the aggregate sum on July 1 of the year next succeeding the year of addition;

(2) Fifteen percent of the aggregate sum on July 1 of each of the succeeding 2 years;

(3) Ten percent of the aggregate sum on July 1 of the next succeeding year;

(4) Three percent of the aggregate sum on July 1 of each of the next 3 succeeding years;

(5) Two percent of the aggregate sum on July 1 of each of the next 3 succeeding years; and

(6) One percent of the aggregate sum on July 1 of each of the next succeeding 10 years.

(d) A supplemental reserve shall be established consisting of any other reserves necessary, when taken in combination with the reserves required by this section, to cover the company's liabilities with respect to all losses, claims, and loss-adjusted expenses.

(e) A title insurer subject to the provisions of this chapter shall file with its annual statement required under Chapter 19 of this title [§ 31-1901 et seq.], a certification by a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer shall conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

(Sept. 24, 2010, D.C. Law 18-223, § 2149, 57 DCR 6242.)

Emergency legislation. — For temporary 2011 Budget Support Emergency Act of 2010 (90 day) addition, see § 2149 of Fiscal Year (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.09. Liquidation, dissolution, or insolvency.

(a) Except as otherwise provided in this section, the IRLA shall apply to all domestic title insurers subject to this chapter. In applying the provisions of the IRLA, the court shall consider the unique aspects of title insurance and shall have broad authority to fashion relief that provides for the maximum protection of the title insurance policyholders.

(b) Indemnity and escrow funds held by or on behalf of the title insurer shall not become general assets and shall be administered as secured creditor claims as provided in the IRLA.

(c) Title insurance policies issued by a domestic title insurer that are in force at the time an order of liquidation is entered shall not be canceled except upon a showing to the court of good cause by the liquidator. The determination of good cause shall be within the discretion of the court. In making this determination, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(d) The court may set appropriate dates that potential claimants shall file their claims with the liquidator as to a domestic title insurer. The court may set different dates for claims based upon the title insurance policy than for all other claims. In setting dates, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(e) As of the date of the order of insolvency or liquidation, all premiums paid, due, or to become due under policies of the domestic title insurers shall be fully earned. It shall be the obligation of agents, insureds, or representatives of the title insurer to pay fully earned premium to the liquidator or rehabilitator.

(Sept. 24, 2010, D.C. Law 18-223, § 2150, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2150 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.10. Restrictions on dividends.

A domestic title insurer shall only declare or distribute a dividend to shareholders without the prior written approval of the Commissioner as would be permitted under § 31-706, for insurers other than life insurers.

(Sept. 24, 2010, D.C. Law 18-223, § 2151, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2151 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.11. Diversification requirement.

(a) Without the prior written approval of the Commissioner, a domestic title insurer shall not accept:

(1) Additional business from a title insurance agent that is not an affiliated company with the insurer if, when added to other business written through the title insurance agent during the same calendar year, that agent's aggregate premiums written on behalf of the title insurer will exceed 20% of the title insurer's gross premiums written during the prior calendar year, as shown on the title insurer's most recent annual statement on file with the Commissioner; or

(2)(A) Additional direct operations business from a single source if, when added to other direct operations business from the single source during the same calendar year, the aggregate premiums written on the direct operations business of the single source will exceed 20% of the title insurer's gross premiums written during the prior calendar year as shown on the title insurers most recent annual statement on file with the Commissioner.

(B) For purposes of this paragraph, the term "single source" means a person that refers business to the title insurer and any other person that controls, is controlled by, or is under common control with, that person.

(b) In determining whether prior approval may be given, the Commissioner shall consider:

(1) The potential that the acceptance of more business from the title insurance producer or source may adversely affect the financial solidity of the title insurer;

(2) The availability of competing title agents or additional sources in the territories in which the title insurer accepts risks;

(3) The number of years that the title insurer has been in business;

(4) Reinsurance arrangements mitigating the concentration of business from the agent or source;

(5) The comparative profitability of the agent's or source's book of business;

(6) The degree of oversight of the agent's operations exercised by the title insurer; and

(7) Any other circumstances considered by the Commissioner to be appropriate.

(Sept. 24, 2010, D.C. Law 18-223, § 2152, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2152 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.12. Direct operations and policyholder treatment.

(a) If a title insurance commitment includes an offer to issue an owner's policy covering the resale of owner-occupied residential property, the title

insurance commitment shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the report cannot be delivered prior to or at closing, the title insurer shall document the reasons for the delay. The title insurance commitment furnished to the purchaser-mortgagor shall incorporate the following statement on the 1st page in bold type:

“Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land.”

(b)(1) A title insurer issuing a lender’s title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the owner-occupied residential property securing the loan, if no owner’s title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the Commissioner, to the purchaser-mortgagor at the time the title insurance commitment is prepared. The notice shall explain:

(A) A lender’s title insurance policy is to be issued protecting the mortgage-lender;

(B) The policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased;

(C) What a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner’s policy; and

(D) The purchaser-mortgagor may obtain an owner’s title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known.

(2) A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least 5 years after the effective date of the policy.

(Sept. 24, 2010, D.C. Law 18-223, § 2153, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2153 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.13. Duties of title insurers utilizing the services of title insurance producers.

(a) The title insurer shall not accept business from a title insurance producer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, if both parties share responsibility for a particular function, specifies the division of responsibilities.

(b) For each title insurance producer under contract with the insurer, the title insurer shall have on file a statement of financial condition of each title

insurance producer as of the end of the previous calendar year setting forth an income statement of business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31st certified by the title insurance producer as being a true and accurate representation of the producer's financial condition.

(c) The title insurer shall, at least annually, conduct an on-site review, or a review conducted electronically that would accomplish the functional equivalent of the same, of the underwriting, claims, and escrow practices of the title insurance producer which shall include a review of the producer's policy blank inventory and processing operations. If the title insurance producer does not maintain separate bank or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance producer.

(d) Within 30 days after executing or terminating a contract with a title insurance producer, the title insurer shall provide written notification of the appointment or termination and the reason for termination to the Commissioner. Notices of appointment of a title insurance producer shall be made on a form promulgated by the Commissioner.

(e) A domestic title insurer shall not appoint to its board of directors an officer, director, employee, controlling shareholder, or any title insurance agent who wrote 1% or more of the title insurer's direct premiums written during the previous calendar year as shown on the title insurer's most recent annual statement on file with the Commissioner. This subsection shall not apply to relationships governed by Chapter 7 of this title [§ 31-701 et seq.].

(f) The title insurer shall maintain an inventory of all policy forms or policy numbers allocated to each title insurance producer.

(g) The title insurer shall have on file proof that the title insurance producer is licensed in the District.

(h) The title insurer shall establish the underwriting guidelines and, if applicable, limitations on title claims settlement authority to be incorporated into contracts with its title insurance producers.

(Sept. 24, 2010, D.C. Law 18-223, § 2154, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2154 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.14. Conditions for maintaining escrow and indemnity deposit accounts.

(a) A title insurer may operate as an escrow, indemnity, settlement, or closing agent, if:

(1) All funds deposited with the title insurer in connection with any escrow, settlement, closing, or indemnity deposit shall be submitted for collection to or deposited in a fiduciary trust account in a qualified financial

institution no later than the close of the next business day in accordance with the following requirements:

(A) The funds shall be the property of the person entitled to them under the provisions of the escrow, settlement, indemnity deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, indemnity deposit, or closing in the records of the title insurer in a manner that permits the funds to be identified on an individual basis; and

(B) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

(b) Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom the funds may be disbursed.

(c) Funds held in an indemnity deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions the Commissioner may require.

(d) Any interest received on funds deposited in connection with any escrow, settlement, indemnity deposit, or closing shall be paid, net of administrative costs, to the depositing party, unless the depositor's instructions for the funds or a governing law provides otherwise.

(e) Disbursements may be made out of an escrow, settlement, or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurer or the insurer's depository;

(3) Checks, drafts, negotiable orders of withdrawal, money orders, and any other item that has been finally paid before any disbursements; provided, that a title insurer may accept a check in an amount not to exceed \$3,000 that has not been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Expedited Funds Availability Act, approved August 10, 1987 (101 Stat. 635; 12 U.S.C. § 4001 et seq.); or

(5) Credit transfers through the Automated Clearing House which have been deemed available by the depository institution receiving the credits transfers and conform to the operating rules set forth by the National Automated Clearing House Association.

(f) This chapter shall not:

(1) Prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction; provided, that all parties consent to the transaction in writing; or

(2) Amend, alter, or supersede other sections of this chapter, or the laws of the District of Columbia or the United States, regarding an escrow holder's duties and obligations.

(g) The Commissioner may prescribe a standard agreement for escrow, settlement, closing, or indemnity deposit funds.

(Sept. 24, 2010, D.C. Law 18-223, § 2155, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2155 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.15. Prohibition of rebate and fee splitting.

A title insurer or other person shall not give or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other service provided by a title insurer.

(Sept. 24, 2010, D.C. Law 18-223, § 2156, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2156 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.16. Favored agent of title insurer.

A title insurer shall not participate in any transaction in which it knows that a title insurance producer or other person requires, directly or indirectly, or through any trustee, director, officer, agent, employee, or affiliate, as a condition precedent to selling or furnishing any other person a loan, or loan extension, credit, sale, property, contract, lease, or service, that the other person shall place a title insurance policy of any kind with the title insurer or through a particular title insurance agent.

(Sept. 24, 2010, D.C. Law 18-223, § 2157, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2157 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.17. Premium rate filings and standards.

(a) A title insurer or title insurance producer may charge any rates regulated by the District of Columbia after January 1, 2011; provided, that in accordance with the premium rate schedule and manual filed by the title insurer with and approved by the Commissioner in accordance with applicable law and rules governing rate filings. The Commissioner may provide, by rule, for interim use of premium rate schedules in effect prior to January 1, 2011.

(b) The Commissioner may establish rules, including rules providing statistical plans, for use by all title insurers and title insurance producers in the

recording and reporting of revenue, loss, and expense experience in such form and detail as is necessary to aid him or her in the establishment of rates and fees.

(c) The Commissioner may require that the information provided under this section be verified by oath of the insurer's or title insurance producer's president or vice president or secretary or actuary, as applicable. The Commissioner may further require that the information required under this section be subject to an audit conducted by an independent certified public accountant. The Commissioner may establish a minimum threshold level at which an audit would be required.

(d) Information filed with the Commissioner relating to the experience of a particular producer shall be kept confidential, subject to subchapter II of Chapter 5 of Title 2 [§ 2-531 et seq.].

(Sept. 24, 2010, D.C. Law 18-223, § 2158, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2158 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.18. Form filing.

(a) A title insurer or authorized rate service organization shall not deliver, issue for delivery, or permit any of its authorized title insurance agents to deliver in the District, any form, in connection with title insurance written, unless it has been filed with the Commissioner and approved by the Commissioner or 30 days have elapsed and it has not been disapproved as misleading or in violation of public policy.

(b) Forms covered by this section shall include:

- (1) Title insurance policies, including standard form endorsements;
- (2) Title insurance commitments issued prior to the issuance of a title insurance policy; and
- (3) Closing protection letters.

(c) After notice and opportunity to be heard are given to the insurer or rate service organization which submitted a form for approval, the Commissioner may withdraw approval of the form on finding that the use of the form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of withdrawal of approval shall not be less than 90 days after notice of withdrawal is given.

(d) An approved policy form or endorsement providing coverage for which no identifiable premium is assessed may be incorporated into every applicable title insurance policy. The insurer shall disclose any additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard of conditions relating to the approved policy forms or endorsements.

(e) Any term or condition related to an insurance coverage provided by an approved title insurance policy or any exception to the coverage, except those ascertained from a search and examination of records relating to a title or

inspection or survey of a property to be insured, shall only be included in the policy after the term, condition, or exception has been filed with the Commissioner and approved.

(Sept. 24, 2010, D.C. Law 18-223, § 2159, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2159 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.19. Filing by rating bureaus.

(a) A title insurer may satisfy its obligation to file premium rates, rating manuals, and forms as required by this chapter if:

(1) It becomes a member of, or a subscriber to, a rate service organization, organized and licensed under the provisions of acts relating to insurance which are codified in this title;

(2) The rate service organization makes the filings; and

(3) It authorizes the Commissioner in writing to accept the filings on the title insurer's behalf.

(b) This chapter shall not:

(1) Require any title insurer to become a member of, or a subscriber to, any rate service organization; and

(2) Prohibit the filing of deviations from rate service organization filings by any member or subscriber.

(Sept. 24, 2010, D.C. Law 18-223, § 2160, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2160 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.20. Record retention requirements.

Evidence of the examination of title and determination of insurability for business written by a title insurer or title insurance producer and records relating to escrow and indemnity deposits shall be preserved and retained by the insurer or agent for as long as appropriate to the circumstances but not less than 3 years after the title insurance policy has been issued or 3 years after the escrow or indemnity deposit account has been closed. This section shall not apply to a title insurer acting as coinsurer if one of the other coinsurers has complied with this section.

(Sept. 24, 2010, D.C. Law 18-223, § 2161, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2161 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.21. Penalties and liabilities.

(a) If the Commissioner determines that the title insurer or any other person has violated this chapter, or any rule or order promulgated under this chapter, after notice and opportunity to be heard, the Commissioner may order:

- (1) A penalty not exceeding \$2,500 for the 1st violation;
- (2) A penalty not exceeding \$5,000 for each successive violation; and
- (3) Revocation or suspension of the title insurer's license.

(b) This section shall affect the right of the Commissioner to impose any other penalties provided for in any acts relating to insurance which are codified in this title.

(Sept. 24, 2010, D.C. Law 18-223, § 2162, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2162 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.22. Violations of Real Estate Settlement Procedures Act ("RESPA").

The Commissioner or Attorney General may bring an action in a court of competent jurisdiction to enjoin or seek remedies for violations of the Real Estate Settlement Procedures Act of 1974, approved December 23, 1974 (88 Stat. 1724; 12 U.S.C. § 2601 et seq.).

(Sept. 24, 2010, D.C. Law 18-223, § 2163, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2163 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.23. Rules; orders.

(a) The Commissioner, through the Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], may issue rules to implement the provisions of this chapter.

(b) The Commissioner may issue orders to implement the provisions of this chapter.

(Sept. 24, 2010, D.C. Law 18-223, § 2164, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2164 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

§ 31-5031.24. Applicability; construction.

(a) This chapter shall:

(1) Apply to all persons engaged in the business of title insurance in the District; and

(2) Supplement the provisions of Chapter 25 of this title [§ 31-2501.01 et seq.].

(b) This chapter shall not:

(1) Except as otherwise provided, limit the application of any acts relating to insurance which are codified in this title; or

(2) Limit or restrict the rights of policyholders, claimants, and creditors.

(c) If there is a conflict between a provision of this chapter and any provision in an act relating to insurance which is codified in this title, Chapter 25 of this title [§ 31-2501.01 et seq.], this chapter shall apply.

(d) This chapter shall apply as of January 1, 2011 and to all transactions entered into after January 1, 2011.

(Sept. 24, 2010, D.C. Law 18-223, § 2165, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2165 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5031.01.

CHAPTER 50B. TITLE INSURANCE PRODUCERS.

Sec.	Sec.
31-5041.01. Definitions.	31-5041.07. Prohibition of rebate and fee splitting.
31-5041.02. Licensing requirements.	31-5041.08. Underwriting contract required with title insurer.
31-5041.03. Examination of operation of title insurance producers.	31-5041.09. Penalties and liabilities.
31-5041.04. Record-retention requirements.	31-5041.10. Violations of the Real Estate Settlement Procedures Act.
31-5041.05. Policyholder treatment.	31-5041.11. Rules.
31-5041.06. Conditions for providing escrow, settlement, closing, and indemnity deposit services.	31-5041.12. Applicability; construction.

§ 31-5041.01. Definitions.

(a) For the purpose of this chapter, the term:

(1) “Abstract of title” means a written history, synopsis, or summary of the recorded instruments affecting a title to real property.

(2) “Affiliate” means, with respect to a person, another person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person.

(3) “Aggrieved party” means a lender, title insurer, consumer, or the District of Columbia, who shall have suffered economic harm as a result of matters insured under any fidelity coverage required under this chapter.

(4) “Attorney” means a person who is admitted to practice law in the District of Columbia.

(5) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(6) “Escrow” means written instruments, money, or other items deposited by a party with a depository, escrow producer, or escrowee for delivery to another party upon the performance of a specified condition or the happening of a certain event.

(7) “Escrow Officer” means a person who maintains an escrow or indemnified deposit account.

(8) “Indemnity” or “indemnity deposit” means funds or other property received by the title insurer as collateral to secure an indemnitor’s obligation under an indemnity agreement pursuant to which the insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage.

(9) “Person” means an individual, partnership, limited liability company, association, cooperative, corporation, trust, or other legal entity.

(10) “Personal property” means stock ownership in a cooperative housing association.

(11) “Producer Licensing Act” means Chapter 11A of this title [§ 31-1131.01 et seq.].

(12) “Qualified financial institution” means an institution that is:

(A) Organized or, in the case of a United States branch or agency office of a non-U.S. banking organization, licensed under the laws of the United States, a state, the District of Columbia, or another jurisdiction of the United States and granted authority to operate with fiduciary powers;

(B) Regulated, supervised, and examined by an authority of the United States, a state, the District of Columbia, or another jurisdiction of the United States having regulatory authority over banks and trust companies;

(C) Insured by the appropriate federal entity; and

(D) Qualified under any additional rules established by the Commissioner.

(13) "RESPA" means the Real Estate Settlement Procedures Act of 1974, approved December 22, 1974 (88 Stat. 1724; 12 U.S.C. § 2601 et seq.).

(14) "Residential property" means real property located in the District of Columbia with one to 4 residential dwelling units in the same or appurtenant structure.

(15) "Subsidiary" means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(16) "Title insurance business" or "business of title insurance" means:

(A) Issuing as an insurer, or offering to issue as an insurer, a title insurance policy;

(B) Engaging in, or proposing to engage in, any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases, and for all liens or charges affecting the same;

(iii) Executing title insurance policies;

(iv) Effecting contracts of reinsurance; or

(v) Abstracting, searching, or examining titles;

(C) Guaranteeing, warranting; or insuring searches or examinations of title to real property or any interest in real property;

(D) Guaranteeing or warranting the status of title as to ownership of or liens on real property or personal property by any person other than the principals to the transaction;

(E) Doing, or holding oneself out to do, business substantially equivalent to any of the activities listed in this paragraph in a manner designed to evade the provisions of this chapter; or

(F) Matters insuring the correctness or marketability of title.

(17) "Title insurance commitment" means a preliminary report or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions, and any other matters under which the title insurer is willing to issue its title insurance policy.

(18) "Title insurance policy" means a contract insuring or indemnifying owners of, or other persons lawfully interested in, real or personal property or an interest in real or personal property against loss or damage arising from any of the following conditions existing on or before the policy date and not expressly excepted or excluded from coverage:

(A) Defects in, or liens or encumbrances on, the insured title;

(B) Unmarketability of the insured title;

(C) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the property;

(D) Lack of legal right of access to the property; or

(E) Unenforceability of rights in title to the property and other matters affecting the title to, or right to use and enjoyment of, the property.

(19)(A) “Title insurance producer” or “producer” means a person who is authorized to perform, on behalf of a title insurer, the following acts in conjunction with the issuance of a title insurance commitment or policy covering residential or personal property situated in the District of Columbia:

(i) Determining insurability and issuing title insurance commitments or policies, or both, based upon the performance or review of a search or abstract of title; and

(ii) Soliciting or negotiating title insurance business.

(B) The term “title insurance producer” or “producer” shall not include:

(i) A financial institution (and its employees) that does not solicit, procure, or negotiate title insurance contracts for compensation or conduct title insurance business;

(ii) An employee of an abstracting company;

(iii) A person whose activities in the District are limited to advertising, without the intent to solicit insurance in the District, through communications in printed publications or other forms of electronic mass media; provided, that the person does not sell, solicit, or negotiate insurance that would insure risks of persons residing in or located in, or activities to be performed, in the District;

(iv) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries of the employer; provided, that the employee does not sell, solicit, or negotiate insurance, or receive a commission;

(v) An employee of a title insurer; provided, that the employee’s activities are not focused on transactions in the District of Columbia, his or her primary responsibilities cover multiple states, and his or her involvement in transactions is to coordinate with title insurance producers licensed in the District of Columbia who conduct title insurance business.

(20) “Title insurer” or “insurer” means a company organized under laws of this state for the purpose of transacting the business of title insurance and any foreign or non-U.S. title insurer licensed in the District to transact the business of title insurance.

(21) “Underwrite” means to accept or reject, or have the authority to accept or reject, risk on behalf of a title insurer.

(Sept. 24, 2010, D.C. Law 18-223, § 2122, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2122 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — Law 18-223, the “Fiscal Year 2011 Budget Support Act of 2010”, was introduced in Council and assigned Bill No. 18-731, which was referred to

the Committee of the Whole. The Bill was adopted on first and second readings on May 26, 2010, and June 15, 2010, respectively. Signed by the Mayor on July 2, 2010, it was assigned Act No. 18-462 and transmitted to both Houses of Congress for its review. D.C. Law 18-223 became effective on September 24, 2010.

Short title. — Short title: Section 2121 of title II of the act may be cited as the “Title D.C. Law 18-223 provided that subtitle L of Insurance Producer Act of 2010”.

§ 31-5041.02. Licensing requirements.

(a) A person shall not act in the capacity of a title insurance producer and a title insurer shall not contract with any person to act in the capacity of a title insurance producer with respect to risks located in the District unless the person is licensed as a title insurance producer in the District of Columbia in accordance with this chapter.

(b)(1) A title insurance producer licensed in the District shall:

(A) Disclose on all correspondence that the producer is acting as an appointed producer for a particular named underwriter;

(B) Exclude or eliminate the word “insurer” or “underwriter” or similar term from its agency’s name; and

(C) Provide, in a timely fashion, each title insurer with which it places business any information the title insurer reasonably requests to comply with reporting requirements of the Commissioner.

(2) A title insurance producer operating in the District of Columbia licensed in the District of Columbia on January 1, 2011, shall have 180 days after January 1, 2011, to comply with the requirements of this subsection.

(c)(1) The Commissioner shall require the title insurance producer to maintain the following coverages for the benefit of the title insurer in amounts commensurate with the producer’s average exposure, under terms and conditions, and from insurers, acceptable to the Commissioner:

(A) An errors and omission policy which includes coverage for a title insurance producer’s delegation of any title insurance producer functions in an amount of not less than \$500,000; and

(B) Fidelity coverage, if the title insurance producer handles escrow or indemnity deposits, in an amount of not less than \$250,000 against which any aggrieved party may assert a claim.

(2) The Commissioner may promulgate rules specifying acceptable alternatives to the preceding insurance requirements. The availability of closing or settlement protection shall not be an acceptable alternative to the requirements of this subsection.

(d) If the title insurance producer delegates the title search to a third party, such as an abstract company, the title insurance producer shall exercise the appropriate diligence, in good faith, to determine that the third party is covered by or maintains the errors and omissions coverage required by subsection (c) of this section.

(e) All funds collected pursuant to this section shall be deposited into the Securities and Banking Regulatory Trust Fund established by § 31-107(b-2).

(Sept. 24, 2010, D.C. Law 18-223, § 2123, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2123 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.03. Examination of operation of title insurance producers.

(a) The Commissioner, during normal business hours, may examine, audit, and inspect any and all books and records required and maintained by a title insurance producer; provided, that trust accounts maintained by attorneys shall be subject to any privilege permitted by law and properly asserted.

(b) The Commissioner may require that the information provided under this section be verified by oath of the title insurance producer or an officer, employee, or accountant of the title insurance producer.

(Sept. 24, 2010, D.C. Law 18-223, § 2124, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2124 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.04. Record-retention requirements.

A title insurance producer shall maintain sufficient records of its affairs, including its escrow operations, if any, and escrow trust accounts, if any, so that the Commissioner may adequately ensure that the title insurance producer is in compliance with this chapter. The Commissioner may prescribe the specific record entries and documents to be kept and the length of time for which the records shall be maintained, for a period of not to exceed 3 years, unless otherwise required by the RESPA.

(Sept. 24, 2010, D.C. Law 18-223, § 2125, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2125 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.05. Policyholder treatment.

(a) Unless otherwise agreed upon in writing, if a title insurance commitment is issued preparatory to issuing an owners title insurance policy covering the sale of owner-occupied residential property of 4 or fewer units, the title insurance producer or insurer shall furnish the title insurance commitment no later than the time of closing. The commitment shall be accompanied by the following statement on the 1st page in bold type:

“Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters which are not covered under the terms of the title insurance policy and should be carefully considered. It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects, and encumbrances affecting title to the land.”

(b)(1) A title insurance producer or insurer which has been requested to issue a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of residential, owner-

occupied property securing the loan, where no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the Commissioner, to the purchaser-mortgagor at the time the commitment is prepared. The notice shall explain:

(A) A lender's title insurance policy is to be issued protecting the mortgage-lender;

(B) The policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased;

(C) What a title policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's policy; and

(D) The purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost, if the proposed coverages or amount of insurance is not then known.

(2) A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least 3 years after the effective date of the policy.

(Sept. 24, 2010, D.C. Law 18-223, § 2126, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2126 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.06. Conditions for providing escrow, settlement, closing, and indemnity deposit services.

(a) All funds deposited with the title insurance producer or insurer in connection with an escrow, settlement, closing, or indemnity deposit shall be submitted for collection to or deposited in a fiduciary trust account in accordance with Chapter 24 of Title 42 [§ 42-2401 et seq.], unless otherwise agreed upon in writing, and in accordance with the following requirements:

(1) The funds shall be the property of the person entitled to them under the provisions of the escrow, settlement, indemnity deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, indemnity deposit, or closing in the records of the title insurance producer in a manner that permits the funds to be identified on an individual basis; and

(2) The funds shall be applied only in accordance with the terms of the individual instructions, settlement statement, or agreements under which the funds were accepted.

(b) Funds held in an indemnity deposit account shall be disbursed only pursuant to a written agreement specifying:

(1) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(2) The duties of the title insurance producer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(3) Any other provisions that the Commissioner may require.

(c) Any interest received on funds deposited in connection with any escrow, settlement, indemnity deposit, or closing shall be paid, net of administrative costs, to the depositing party, unless the depositor's written instructions for the funds, a court order, or a governing law provides otherwise.

(d) Disbursements may be made out of an escrow, settlement, or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(1) Cash;

(2) Wire transfers such that the funds are unconditionally received by the title insurance producer, title insurer, or depository of either;

(3) Checks, drafts, negotiable orders of withdrawal; money orders, and any other item that has been finally paid before any disbursements; provided, that a title insurance producer may accept a check in an amount not to exceed \$3,000 that has not been finally paid before any disbursements;

(4) A depository check, including a certified check, governed by the provisions of the Expedited Funds Availability Act, approved August 10, 1987 (101 Stat. 635; 12 U.S.C. § 4001 et seq.); or

(5) Credit transfers through the Automated Clearing House which have been deemed available by the depository institution receiving the credit transfers and conform to the operating rules set forth by the National Automated Clearing House Association.

(e) This chapter shall not prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction that does not relate to residential property; provided, that all parties consent to the transaction in writing.

(f) A title insurance producer who maintains or operates fiduciary trust accounts in connection with providing escrow, closing settlement services shall have an annual audit made of its escrow, settlement, closing, and indemnity deposit accounts, conducted by an accountant on a calendar year basis at its expense within 90 days after the close of the previous calendar year. Alternatively, any title insurer, at its expense, may conduct, or cause to be conducted, an annual audit of the escrow, settlement, closing, and security deposit accounts of the title insurance producer, subject to the rules by the Commissioner as hereinafter set forth. By April 30th of each year, the title insurance producer shall provide a copy of the audit report to each title insurer which it represents or for which it was an appointed producer with the Company. The Commissioner may promulgate rules setting forth the minimum threshold level at which an audit would be required, the standards of audit, and the forms of audit report required. Title insurance producers who are attorneys licensed in any state or the District of Columbia, who are not exclusively in the business of title insurance, and who issue title insurance policies as part of their legal representation of clients shall be exempt from the requirements of this subsection; provided, that the title insurer may, at its expense, conduct, or cause to be conducted, an annual review or audit of the escrow, settlement, closing, and indemnity deposit accounts of the attorney. The Commissioner

may also require the title insurance producer or escrow agent to provide a copy of its audit report to the Commissioner.

(g) If the title insurance producer is appointed by 2 or more title insurers and maintains fiduciary trust accounts in connection with providing escrow, closing settlement services, the title insurance producer shall allow each title insurer reasonable access to the accounts and any or all of the supporting account information to ascertain the safety and security of the funds held by the title insurance producer.

(h) The Commissioner may prescribe standard disclosures that must be included in all agreements for escrow, settlement, closing, or indemnity deposits.

(Sept. 24, 2010, D.C. Law 18-223, § 2127, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2127 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.07. Prohibition of rebate and fee splitting.

(a) In a residential property transaction, a title insurer, or any employee or representative of a title insurer, shall not pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any valuable consideration or inducement, whether or not specified or provided for in the policy, except to the extent provided for in an applicable filing with the Commissioner as provided by law.

(b) In a residential property transaction, an insured named in a policy, or any employee of the insured, shall not knowingly receive or accept, directly or indirectly, any rebate, discount, abatement, credit, or reduction of premium, or any special favor, advantage, valuable consideration, or inducement, as specified in subsection (a) of this section.

(c) This section shall not prohibit:

(1) The payment of commissions or other compensation to domestic or foreign licensed title insurance producers or title insurer employees; or

(2) Any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits.

(Sept. 24, 2010, D.C. Law 18-223, § 2128, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2122 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.08. Underwriting contract required with title insurer.

A person acting in the capacity of a title insurance producer shall not place business with a title insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and, if both parties share responsibility for a particular function, specifies the division of the responsibilities.

(Sept. 24, 2010, D.C. Law 18-223, § 2129, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2129 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.09. Penalties and liabilities.

(a) If the Commissioner determines that the title insurance producer or any other person has violated this chapter, or any rule or order promulgated under this chapter, after notice and opportunity to be heard, the Commissioner may order:

- (1) A penalty not exceeding \$2,500 for the 1st violation;
- (2) A penalty not exceeding \$5,000 for each successive violation; and
- (3) Revocation or suspension of the title insurance producer's or title insurer's license.

(b) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to Chapter 13 of this title [§ 31-1301 et seq.], and the receiver appointed under that order determines that the title insurance producer or any other person has not complied with this chapter, or any related rule or order, and the insurer suffered any resulting loss or damage, the receiver may maintain an action for recovery of damages or other appropriate sanctions for the benefit of the insurer and its policyholders and creditors.

(c) This section shall not affect the right of the Commissioner to impose any other penalties provided for in acts relating to insurance which are codified in this title.

(Sept. 24, 2010, D.C. Law 18-223, § 2130, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2130 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.10. Violations of the Real Estate Settlement Procedures Act.

The Commissioner or Attorney General for the District of Columbia may bring an action to enjoin or seek remedies for violations of RESPA.

(Sept. 24, 2010, D.C. Law 18-223, § 2131, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2131 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.11. Rules.

The Commissioner, through the Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], may issue rules to implement the provisions of this chapter.

(Sept. 24, 2010, D.C. Law 18-223, § 2132, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2132 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

§ 31-5041.12. Applicability; construction.

(a) This chapter shall:

(1) Apply to all persons engaged in the business of title insurance in the District;

(2) Supplement the provisions of Chapter 11A of this title [§ 31-1131.01 et seq.].

(b) This chapter shall not:

(1) Except as otherwise provided, limit the application of any insurance law codified in this title; or

(2) Limit or restrict the rights of policyholders, claimants, and creditors.

(c) If there is a conflict between a provision of this chapter and any other act relating to insurance which is codified in this title, including Chapter 11A of this title [§ 31-1131.01 et seq.], this chapter shall apply.

(d) This chapter shall apply as of January 1, 2011, and to all transactions entered into after January 1, 2011.

(Sept. 24, 2010, D.C. Law 18-223, § 2133, 57 DCR 6242.)

Emergency legislation. — For temporary (90 day) addition, see § 2133 of Fiscal Year 2011 Budget Support Emergency Act of 2010 (D.C. Act 18-463, July 2, 2010, 57 DCR 6542).

Legislative history of Law 18-223. — For Law 18-223, see notes following § 31-5041.01.

SUBTITLE VIII. PROVISIONS APPLICABLE TO MORE THAN ONE KIND OF INSURANCE.

CHAPTER 51. CREDIT LIFE, ACCIDENT, AND HEALTH INSURANCE.

Sec.	Sec.
31-5101. Short title; applicability of provisions.	31-5108. Refunds, credits and charges.
31-5102. Definitions.	31-5109. Claims.
31-5103. Forms authorized to be issued.	31-5110. [Repealed].
31-5104. Limitations on amount.	31-5110.01. [Repealed].
31-5105. Term of coverage.	31-5111. Violations.
31-5106. Required policies or certificates; contents; delivery; applications and notices.	31-5112. Administrative or judicial review of orders or actions.
31-5107. Filing requirements; forms and rates to be approved by Commissioner.	

§ 31-5101. Short title; applicability of provisions.

(a) This chapter regulating credit life insurance and credit accident and health insurance in the District of Columbia may be cited as “The Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance.”

(b) All life insurance and all accident and health insurance in connection with loans or other credit transactions of less than 5 years duration in the District of Columbia shall be subject to the provisions of this chapter. Such insurance written in connection with a loan or other credit transaction of 5 years duration or more shall not be subject to the provisions of this chapter, nor shall such insurance be subject to the provisions of this chapter if the issuance of the insurance is an isolated transaction on the part of the insurer not related to a plan or regular course of conduct for insuring debtors of the creditor.

(c) Repealed.

(Sept. 25, 1962, 76 Stat. 580, Pub. L. 87-686, § 1; Apr. 3, 2001, D.C. Law 13-263, § 1411(b)(1), 48 DCR 991; May 7, 2002, D.C. Law 14-132, § 602(a).)

Prior Codifications. — 1981 Ed., § 35-1001.

1973 Ed., § 35-1601.

Effect of amendments. — D.C. Law 13-263 added subsec. (c).

D.C. Law 14-132 repealed subsec. (c) which had read:

“(c) Sections §§ 31-5110.01, 31-5111, and 31-5112 shall apply to an insurance plan or program for which an application of approval has been submitted to the Commissioner under § 42-836.01(2)(B).”

D.C. Law 15-105 purported to amend subsec. (c) which was repealed by D.C. Law 14-132, therefore, the amendment was ineffective.

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Protections from Predatory Lending and Mortgage Foreclosure Improvements Temporary Amendment Act of 2001 (D.C. Law 14-

86, March 19, 2002, law notification 49 DCR 2991).

Emergency legislation. — Section 2 of Act 14-188, the “Protections from Predatory Lending and Mortgage Foreclosure Improvements Emergency Amendment Act”, deemed approved Nov. 27, 2001, without the signature of the Mayor, provided that D.C. Law 13-263 shall not apply beginning November 6, 2001, through March 6, 2002.

Legislative history of Law 13-263. — Law 13-263, the “Protections from Predatory Lending and Mortgage Foreclosure Improvements Act of 2000,” was introduced in Council and assigned Bill No. 13-800, which was referred to the Committee on Economic Development. The Bill was adopted on first and second readings on November 8, 2000, and December 5, 2000, respectively. Signed by the Mayor on December 21, 2000, it was assigned Act No. 13-552 and

transmitted to both Houses of Congress for its review. D.C. Law 13-263 became effective on April 3, 2001.

Legislative history of Law 14-132. — Law 14-132, the “Home Loan Protection Act of 2002”, was introduced in Council and assigned Bill No. 14-515, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on February 5, 2002, and February 19, 2002, respectively. Signed by the Mayor on March 1, 2002, it was assigned Act No. 14-296 and transmitted to both Houses of Congress for its review. D.C. Law 14-132 became effective on May 7, 2002.

Legislative history of Law 15-105. — For Law 15-105, see notes following § 31-2402.

§ 31-5102. Definitions.

For the purpose of this chapter:

(1) “Mayor” means the Mayor of the District of Columbia.

(1A) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(2) “Credit life insurance” means insurance issued on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(3) “Credit accident and health insurance” means insurance against the disability of a debtor which provides indemnity for payments on a specific loan or other credit transaction.

(4) “Creditor” means the lender of money or vendor of goods, services, or property, including a lessor under a lease intended as a security, for which payment is arranged through a loan or other credit transaction, and includes any successor to the right, title, or interest of any such lender, vendor, or lessor.

(5) “Debtor” means a borrower of money or purchaser of goods, services, or property, including a lessee under a lease intended as a security, for which payment is arranged through a loan or other credit transaction.

(6) “District” means the District of Columbia.

(7) “Indebtedness” means the amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(8) Repealed.

(Sept. 25, 1962, 76 Stat. 580, Pub. L. 87-686, § 2; May 21, 1997, D.C. Law 11-268, § 10(m), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 25(a), 45 DCR 745; June 11, 2004, D.C. Law 15-166, § 4(dd), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-1002.

1973 Ed., § 35-1602.

Effect of amendments. — D.C. Law 15-166, in par. (1A), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(dd) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill

No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on November 4, 1997 and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned

Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and

Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5103. Forms authorized to be issued.

Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

- (1) Individual policies of life insurance issued to debtors on the term plan;
- (2) Individual policies of accident and health insurance issued to debtors on a term plan or disability provisions in individual life policies to provide such coverage;
- (3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and
- (4) Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability provisions in group life policies to provide such coverage.

(Sept. 25, 1962, 76 Stat. 581, Pub. L. 87-686, § 3.)

Prior Codifications. — 1981 Ed., § 35-1003. 1973 Ed., § 35-1603.

§ 31-5104. Limitations on amount.

- (a) The amount of credit life insurance shall not exceed the initial indebtedness however the indebtedness may be repayable; provided, however, that nothing contained herein shall be deemed to supersede or repeal the limitation

on the amount of group insurance specified in § 31-4710(2)(D) [repealed]. In cases where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled amount of unpaid indebtedness in the case of any individual policy or the actual amount of the unpaid indebtedness in the case of any group policy.

(b) The amount of indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

(c) Notwithstanding subsections (a) and (b) of this section, the amount of any credit life insurance or credit accident and health insurance with respect to indebtedness incurred to defray educational costs of a student may include the part of a commitment that has not been advanced by the creditor.

(Sept. 25, 1962, 76 Stat. 581, Pub. L. 87-686, § 4; Sept. 20, 1966, 80 Stat. 821, Pub. L. 89-594, § 2.)

Prior Codifications. — 1981 Ed., § 35-1004. 1973 Ed., § 35-1604.

§ 31-5105. Term of coverage.

The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurance company, commence on the date when the debtor becomes obligated to the creditor, except that where a group policy provides coverage with respect to existing obligations the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days from the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewal or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in § 31-5108.

(Sept. 25, 1962, 76 Stat. 581, Pub. L. 87-686, § 5.)

Section references. — This section is referred to in § 31-5106. 1973 Ed., § 35-1605.

Prior Codifications. — 1981 Ed., § 35-1005.

§ 31-5106. Required policies or certificates; contents; delivery; applications and notices.

(a) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy or in the case of group insurance by a group policy and individual certificates of insurance.

(b) Each individual policy or certificate of credit life insurance, each individual policy or certificate of credit accident and health insurance, and each individual policy or certificate of credit life insurance and credit accident and health insurance shall, in addition to other requirements of law, set forth the name and home office address of the insurance company, and the identity by name or otherwise of the person insured, the rate or amount of payment, if any, by the debtor separately in connection with credit life insurance and credit accident and health insurance, a description of the coverage, including the amount and term thereof (which in the case of group insurance may be by description rather than stated amount and term), any exceptions, limitations, or restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, whenever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(c) Except as hereinafter provided, an individual policy or certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred.

(d) If a debtor makes a separate payment for credit life or credit accident and health insurance and an individual policy or certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance shall be delivered at such time to the debtor by the creditor. The copy of the application for or notice of proposed insurance shall be signed by the debtor and shall set forth the identity by name or otherwise of the person insured; the rate or amount of payment by the debtor separately for credit life insurance and credit accident and health insurance; and a statement that within 30 days, if the insurance is accepted by the insurance company, there will be delivered to the debtor an individual policy or certificate of insurance containing the name and home office address of the insurance company, and a description of the amount, term, and coverage including any exceptions, limitations, and restrictions. The copy of the application for, or notice of, proposed insurance shall refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement unless the information required by this subsection is prominently set forth in such statement of account, instrument, or agreement. If a debtor does not make a separate payment for credit life or credit accident and health insurance, an application need not be taken or a notice of proposed insurance given. In any case, upon acceptance of the insurance by the insurance company, and within 30 days of the date upon which the term of the insurance commences, the insurance company shall cause the individual policy or certificate of insurance

to be delivered to the debtor. Said application or notice of proposed insurance shall state that, upon acceptance by the insurance company, the insurance shall become effective as provided in § 31-5105.

(Sept. 25, 1962, 76 Stat. 581, Pub. L. 87-686, § 6.)

Prior Codifications. — 1981 Ed., § 35-1006. 1973 Ed., § 35-1606.

§ 31-5107. Filing requirements; forms and rates to be approved by Commissioner.

(a) All forms of policies, certificates of insurance, notices of proposed insurance, applications for insurance, binders, endorsements and riders delivered or issued for delivery in the District and the premium rates pertaining thereto shall be filed with the Commissioner by the insurance company, in such manner and together with such supporting information as the Commissioner may reasonably require. In any case where a group policy is made for a group in the District and the policy is neither delivered nor issued for delivery in the District, the form of policy and all other forms and premium rates referred to in the preceding sentence shall be filed with the Commissioner by the insurance company.

(b) The Commissioner may, within 30 days after the filing of any form of policy, certificate of insurance, notice of proposed insurance, application for insurance, binder, endorsement or rider, disapprove any such form if the premium rates charged or to be charged appear by reasonable assumptions to be excessive in relation to benefits paid or to be paid, or if the form contains provisions which are unjust, unfair, inequitable, misleading, or deceptive. In determining whether to disapprove any such form the Commissioner may give due consideration to past and prospective loss experience within and outside the District, to underwriting practice and judgment to the extent appropriate, and to all other relevant factors within and outside the District, and he may take into account the experience of the individual company.

(c) If the Commissioner notifies the insurance company that the form does not comply with the requirements of this chapter, it shall be unlawful thereafter for such insurance company to issue or use such form. In such notice, the Commissioner shall specify the reason for his disapproval and state that a hearing will be granted promptly upon request in writing by the insurance company. No such policy, certificate of insurance, notice of proposed insurance, application for insurance, binder, endorsement, or rider shall be issued or used until the expiration of 30 days after it has been so filed, unless the Commissioner shall give his prior written approval thereto.

(d) The Commissioner may, at any time after a hearing, held after not less than 20-days written notice to the insurance company, withdraw his approval of any such form if it does not meet the requirements of this chapter.

(e) The insurance company shall not issue such forms or use them after the effective date of such withdrawal of approval.

(f) The insurance company may revise such forms and the premium rates pertaining thereto from time to time, and such revised forms and premium

rates shall be filed with the Commissioner and shall be subject to all the preceding requirements of this section, in like manner as though they were original filings with the Commissioner.

(Sept. 25, 1962, 76 Stat. 582, Pub. L. 87-686, § 7; May 21, 1997, D.C. Law 11-268, § 10(m), 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 25(b), 45 DCR 745.)

Prior Codifications. — 1981 Ed., § 35-1007.

1973 Ed., § 35-1607.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5102.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see Historical and Statutory Notes following § 31-5102.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5102.

§ 31-5108. Refunds, credits and charges.

(a) Each individual policy or certificate of credit life insurance or credit accident and health insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, that the Commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing refunds shall be filed with the Commissioner who may disapprove such formula if he finds that it is unjust or unreasonable.

(b) If a creditor requires a debtor to make a payment in connection with credit life insurance or credit accident and health insurance and an individual policy or certificate of insurance is not issued, the creditor shall promptly give written notice to such debtor and shall promptly make an appropriate credit to the account.

(c) The amount charged to a debtor for credit life or credit accident and health insurance shall not exceed the premium rate charged by the insurance company at the time the charge to the debtor is determined.

(Sept. 25, 1962, 76 Stat. 583, Pub. L. 87-686, § 8; May 21, 1997, D.C. Law 11-268, § 10(m), 44 DCR 1730.)

Section references. — This section is referred to in § 31-5105.

Prior Codifications. — 1981 Ed., § 35-1008.

1973 Ed., § 35-1608.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5102.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5102.

§ 31-5109. Claims.

(a) All claims shall be paid either by draft drawn upon the insurance company or by check of the insurance company to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon

direction of such claimant to one specified, and every insurance company shall be held to strict settlement of all such claims.

(b) It shall be unlawful for any creditor, having received any such check or draft from such insurance company, to fail to correctly credit the account, pay to or upon the direction of, or otherwise correctly account to the claimant to whom payment is due for the full amount of such check or draft, less any lawful deductions therefrom.

(c) No plan or arrangement shall be used whereby any person, firm, or corporation other than the insurance company or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurance company in adjusting claims, nor, in the case of an individual creditor, shall the spouse of such creditor or any relative of the creditor or spouse within the 3rd degree of consanguinity be so designated, nor shall any officer or employee of a corporate creditor or any spouse or relative of such officer, employee, or spouse within the 3rd degree of consanguinity be so designated; provided, that a group policyholder may, by arrangement with the group insurance company, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurance company.

(Sept. 25, 1962, 76 Stat. 584, Pub. L. 87-686, § 9.)

Prior Codifications. — 1981 Ed., § 35-1009. 1973 Ed., § 35-1609.

§ 31-5110. Choice of companies to provide required coverage. [Repealed].

Repealed.

(Sept. 25, 1962, 76 Stat. 584, Pub. L. 87-686, § 10; Apr. 3, 2001, D.C. Law 13-265, § 126(b), 48 DCR 1225, redesignated § 302, Oct. 19, 2002, D.C. Law 14-213, § 20(b), 49 DCR 8140.)

Prior Codifications. — 1981 Ed., § 35-1010. D.C. Law 13-265, see notes following § 31-2231.01.

1973 Ed., § 35-1610.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

§ 31-5110.01. Insurance plans and programs submitted pursuant to § 42-836.01(2)(B). [Repealed].

Repealed.

(Sept. 25, 1962, 76 Stat. 580, Pub. L. 87-686, § 10a, as added Apr. 3, 2001, D.C. Law 13-263, § 1411(b)(2), 48 DCR 991; May 7, 2002, D.C. Law 14-132, § 602(a).)

Temporary Amendment of Section. — For temporary (225 day) amendment of section, see § 2 of Protections from Predatory Lending and Mortgage Foreclosure Improvements Tem-

porary Amendment Act of 2001 (D.C. Law 14-86, March 19, 2002, law notification 49 DCR 2991).

Emergency legislation. — Section 2 of Act

14-188, the "Protections from Predatory Lending and Mortgage Foreclosure Improvements Emergency Amendment Act", deemed approved Nov. 27, 2001, without the signature of the Mayor, provided that D.C. Law 13-263 shall not apply beginning November 6, 2001, through March 6, 2002.

Legislative history of Law 13-263. — For D.C. Law 13-263, see notes following § 31-5101.

Legislative history of Law 14-132. — Law 14-132, the "Home Loan Protection Act of 2002", was introduced in Council and assigned Bill No. 14-515, which was referred to the

Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on February 5, 2002, and February 19, 2002, respectively. Signed by the Mayor on March 1, 2002, it was assigned Act No. 14-296 and transmitted to both Houses of Congress for its review. D.C. Law 14-132 became effective on May 7, 2002.

Effective date. — Section 602(a) of Law 14-132 provided: "The Protections from Predatory Lending and Mortgage Foreclosure Improvements Act of 2000, effective April 3, 2001 (D.C. Law 13-263; 48 DCR 991), is repealed as of November 6, 2001."

§ 31-5111. Violations.

(a) In the case of any violation of this chapter by an insurance company, agent, solicitor, or broker, the Commissioner shall have authority to proceed in accordance with the provisions of §§ 31-4305 and 31-4326 [repealed] and §§ 31-2502.03 and 31-2502.36 [repealed].

(b) In the case of any violation of this chapter by a creditor or by any other person not licensed in the District as an insurance agent, solicitor, or broker, regardless of the fact that such creditor or other person is not required by law to be so licensed, the penalties and the procedure for their imposition shall be as set forth in § 31-2502.42.

(Sept. 25, 1962, 76 Stat. 584, Pub. L. 87-686, § 11; May 21, 1997, D.C. Law 11-268, § 10(m), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1011.

1973 Ed., § 35-1611.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-5102.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5102.

§ 31-5112. Administrative or judicial review of orders or actions.

Any insurance company, agent, solicitor, or broker aggrieved by any order or action of the Commissioner under this chapter may contest the validity of such order or action by appeal or through any other appropriate proceeding, in accordance with the procedures prescribed by §§ 31-2502.43 [repealed] and 31-2502.44 [repealed]; provided, that any such insurance company, agent, solicitor, or broker, which is licensed in the District under Subdivision A of Subtitle VI of this title, may contest the validity of such order or action by appeal or through any other appropriate proceeding in accordance with the procedures prescribed by Subdivision A of Subtitle VI of this title.

(Sept. 25, 1962, 76 Stat. 585, Pub. L. 87-686, § 12; May 21, 1997, D.C. Law 11-268, § 10(m), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1012.

1973 Ed., § 35-1612.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5102.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5102.

CHAPTER 52. GENERAL PROVISIONS.

Sec.

31-5201. Maintenance of reinsurance reserve fund by life and fire insurance companies or associations; suspension or revocation of license for insolvency or impairment of capital; aiding unlicensed companies or associations; issuance of license.

31-5202. "Health, accident, and life insurance companies" defined; assets or capital stock requirements; annual required tax and financial statement; annual required examinations; revocation or suspension of

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license; appeal; issuance of license; exemptions.

31-5203. Copy of application by insured to be delivered with policy.

31-5204. Principal office and books, records, and files of corporation to be in District; exception; reincorporation of certain corporations; violations; prosecutions.

31-5205. Employees' compensation corporations or associations to file certain information with Commissioner; disapproval of premium rate or schedule; judicial review.

§ 31-5201. Maintenance of reinsurance reserve fund by life and fire insurance companies or associations; suspension or revocation of license for insolvency or impairment of capital; aiding unlicensed companies or associations; issuance of license.

(a) All life and fire insurance companies or associations licensed to do business in said District shall be required to maintain a reinsurance reserve fund; and whenever any such company or association not excepted from the operations hereof shall become insolvent or impaired to the extent of 25% of its capital stock it shall be the duty of the Commissioner to suspend its license; and unless such impairment or insolvency shall be made good within 60 days thereafter, it shall be the duty of the Commissioner of the Department of Insurance, Securities, and Banking to revoke its license to do business in the District; and it shall be unlawful for any insurance company, association, or order to do business in the District without a license, or to continue business after the revocation of its license, and any such company or association violating this provision shall be liable to a penalty of \$20 for each day it transacts business without such license to be recovered by the Mayor of the District by an action of debt in any court of the District of competent jurisdiction. And any person who shall aid in carrying on the business of any such company, or shall act as agent or solicitor for any company not licensed to do business in said District, or whose license is revoked, shall be guilty of a misdemeanor, and on conviction thereof in the Superior Court of the District of Columbia shall be punished by a fine not exceeding \$100, or, in default of payment thereof, by imprisonment in the jail of the District for not less than 10 nor more than 60 days. And the Commissioner of the Department of Insurance, Securities, and Banking shall issue such license to any such insurance company or association whenever it shall have complied with the provisions of § 31-202, subject, however, to the provisions of §§ 31-5901 [repealed] and 31-5902 [repealed]; provided, that the Commissioner of the Department of Insurance, Securities, and Banking shall have power to make an official

examination into the affairs of any insurance company or association organized under the laws of the District of Columbia, or having its principal office therein, at his discretion, for the purpose of ascertaining whether such company is impaired or insolvent, as aforesaid. Civil fines, penalties, and fees may be imposed as alternative sanctions for any infraction of the provisions of this section, or any rules or regulations issued under the authority of this section, pursuant to Chapter 18 of Title 2. Adjudication of any infraction of this section shall be pursuant to Chapter 18 of Title 2.

(b) Any license issued pursuant to this section shall be issued as a Financial Services endorsement to a basic business license under the basic business license system as set forth in subchapter I-A of Chapter 28 of Title 47.

(Mar. 3, 1901, 31 Stat. 1290, ch. 854, § 648; Apr. 1, 1942, 56 Stat. 190, ch. 207, § 1; July 8, 1963, 77 Stat. 77, Pub. L. 88-60, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); Oct. 5, 1985, D.C. Law 6-42, § 470(d), 32 DCR 4450; May 21, 1997, D.C. Law 11-268, § 10(d), 44 DCR 1730; Apr. 20, 1999, D.C. Law 12-261, § 2003(gg)(1), 46 DCR 3142; Oct. 28, 2003, D.C. Law 15-38, § 3(t)(2), 50 DCR 6913; June 11, 2004, D.C. Law 15-166, § 4(ee), 51 DCR 2817.)

Cross references. — Authority of Council to regulate, modify, or eliminate license requirements and to promulgate regulations, see §§ 47-2842, 47-2844.

Claims of creditors, benefits from health and accident insurance, see § 31-4716.01.

Deposits of life insurance companies, see § 31-4315 et seq.

Fire, casualty, and marine insurance companies, capital requirements, see § 31-2502.13.

Fire, casualty, and marine insurance companies, licensing, see § 31-2502.02.

Impairment of capital, see § 31-5202.

Inspection and examination of insurance companies, see §§ 31-208 and 31-5202.

Minors' contract for health and accident insurance, see § 31-4330.

Section references. — This section is referred to in § 31-4901.

Prior Codifications. — 1981 Ed., § 35-201. 1973 Ed., § 35-201.

Effect of amendments. — D.C. Law 15-38, in subsec. (b), substituted "Financial Services endorsement to a basic business license under the basic" for "Class A Financial Services endorsement to a master business license under the master".

D.C. Law 15-166, in subsec. (a), substituted "Commissioner of the Department of Insurance, Securities, and Banking" for "Commissioner of Insurance and Securities" throughout the subsection.

Emergency legislation. — For temporary (90 day) amendment of section, see § 3(t)(2) of Streamlining Regulation Emergency Act of 2003 (D.C. Act 15-145, August 11, 2003, 50 DCR 6896).

For temporary (90 day) amendment of section, see § 4(ee) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 6-42. — Law 6-42, the "Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985," was introduced in Council and assigned Bill No. 6-187, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 25, 1985, and July 9, 1985, respectively. Signed by the Mayor on July 16, 1985, it was assigned Act No. 6-60 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — Law 11-268, the "Department of Insurance and Securities Regulation Establishment Act of 1996," was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 12-261. — Law 12-261, the "Second Omnibus Regulatory Reform Amendment Act of 1998," was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 1, 1998, and December 15, 1998, respectively. Signed by the Mayor on

December 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Legislative history of Law 15-38. — For Law 15-38, see notes following § 31-1103.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property, records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were trans-

ferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities, and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5202. “Health, accident, and life insurance companies” defined; assets or capital stock requirements; annual required tax and financial statement; annual required examinations; revocation or suspension of license; appeal; issuance of license; exemptions.

Every corporation, joint-stock company, or association not exempt herein, transacting business in the District of Columbia, which collects premiums, dues, or assessments from its members or from holders of its certificates or policies, and which provides for the payment of indemnity on account of sickness or accident, or a benefit in case of death, shall be known as “health, accident, and life insurance companies or associations.” No such company or association shall transact business within the District of Columbia unless it shall have in assets or in capital stock fully paid up in cash, or in both together, not less than \$25,000 as a capital or guarantee fund; which assets may be invested in United States, state, county, municipal bonds, and bonds of the District of Columbia, or railroad bonds; but investments in the bonds of railroads shall be limited to the bonds of those railroads which have paid dividends on their capital stock for the 10 years immediately previous to the

date of the investment; or in improved real estate, or in first mortgages on improved real estate; but no loan on real estate shall be made for an amount exceeding 70% of its assessed value, such investments to be approved by the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] of the District of Columbia. No such health, accident, and life insurance company or association, transacting on August 15, 1911, or thereafter the business of health, accident, and life insurance, or either or all said kinds of insurance, in the District of Columbia shall issue policies or certificates providing, either singly or in aggregate, a greater accident or death benefit than \$500, or a greater weekly indemnity than \$20, on any 1 person unless such company or association has in assets or in capital stock fully paid up in cash, or in both together, not less than \$100,000 invested and approved as aforesaid. Every such company or association shall pay to the Collector of Taxes for the District of Columbia a sum of money, as tax, equal to 1% of all moneys received from members of policy or certificate holders within the District of Columbia, said tax to be paid on or before the 1st day of March of each year on the amount of such income for the year ending December 31st next preceding; and shall also file annually with said Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking], on or before the 1st day of March of each year, a sworn statement, on blanks furnished by said Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking], showing its true financial condition, income, disbursements, assets, and liabilities on the 31st of December next preceding, and such other information as said Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] may require; and shall pay to the said Collector of Taxes \$10 for filing such statement. All companies or associations described herein shall be examined as described in Chapter 14 of this title; and when the Mayor finds the capital stock of any such company impaired or its assets reduced in value to an amount less than required by the provisions hereof he shall at once give notice of said fact to said company or association, and unless said impairment is made good within 60 days after said notice, it shall be the duty of said Commissioner to revoke or suspend the license of said company or association until such impairment shall have been made good; and any company or association that issues policies or certificates of insurance as described herein without a license from said Commissioner or during a suspension thereof, as herein provided, shall be fined not less than \$20 nor more than \$100 per day; provided, that if any such company or association shall feel aggrieved by the decision of said Commissioner concerning the investment or impairment of its assets or capital stock, it shall have the right to appeal, within 10 days, from the decision of said Commissioner to the Mayor of the District of Columbia, and the Council of the District of Columbia shall prescribe rules and regulations for the hearing of said appeal, and the Mayor's decision shall be final; provided also, that when any such company or association shall have complied with the provisions contained herein, the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] shall issue to

it a license to transact its business in the District of Columbia; provided, however, that nothing contained herein shall interfere with or abridge the rights of any fraternal beneficial association licensed to transact business under §§ 31-5701 to 31-5717 [repealed], or incorporated by special act of Congress; and provided further, that nothing contained herein shall apply to any relief association, not conducted for profit, composed solely of officers and enlisted men of the United States Army, Navy, or Air Force, or solely of employees of any other branch of the United States government service, or solely of employees of any individual, company, firm, or corporation. Civil fines, penalties, and fees may be imposed as alternative sanctions for any infraction of the provisions of this section, or any rules or regulations issued under the authority of this section, pursuant to Chapter 18 of Title 2. Adjudication of any infraction of this section shall be pursuant to Chapter 18 of Title 2.

(Mar. 3, 1901, 31 Stat. 1292, ch. 854, § 653; Aug. 15, 1911, 37 Stat. 16, ch. 12, § 1; Oct. 5, 1985, D.C. Law 6-42, § 470(e), 32 DCR 4450; Oct. 21, 1993, D.C. Law 10-49, § 9(a), 40 DCR 6110; May 21, 1997, D.C. Law 11-268, § 10(d), 44 DC 1730.)

Cross references. — Annual statements and taxes, see § 47-2601 et seq.

Domestic life companies, formation, see § 31-4401.

Fire and Casualty Act, provision that health and accident insurance may be written under, see § 31-2502.11.

Fire, casualty, and marine insurance companies, capital and surplus requirements, see § 31-2502.13.

Health and accident insurance, required policy provisions, see § 31-4712.

Inspection and examination of insurance companies, see §§ 31-208 and 31-5201.

Life insurance companies, deposits, see §§ 31-4315 et seq.

Reserves and related actuarial items, submission of opinion with annual statement, see § 31-4901.

Prior Codifications. — 1981 Ed., § 35-202. 1973 Ed., § 35-202.

Legislative history of Law 6-42. — For legislative history of D.C. Law 6-42, see Historical and Statutory Notes following § 31-5201.

Legislative history of Law 10-49. — Law 10-49, the “Law on Examinations Act of 1993,” was introduced in Council and assigned Bill No. 10-131, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-947 and transmitted to both Houses of Congress for its review. D.C. Law 10-49 became effective on October 21, 1993.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see His-

torical and Statutory Notes following § 31-5201.

Editor’s notes. — Office of Collector of Taxes abolished: The Office of the Collector of Taxes was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. All functions of the Office of the Collector of Taxes including the functions of all officers, employees, and subordinate agencies were transferred to the Director, Department of General Administration by Reorganization Order No. 3, dated August 28, 1952. Reorganization Order No. 20, dated November 10, 1952, transferred the functions of the Collector of Taxes to the Finance Office. The same Order provided for the Office of the Collector of Taxes headed by a Collector in the Finance Office, and abolished the previously existing Office of the Collector of Taxes. Reorganization Order No. 20 was superseded and replaced by Organization Order No. 121, dated December 12, 1957, which provided that the Finance Office (consisting of the Office of the Finance Officer, Property Tax Division, Revenue Division, Treasury Division, Accounting Division, and Data Processing Division) would continue under the direction and control of the Director of General Administration, and that the Treasury Division would perform the function of collecting revenues of the District of Columbia and depositing the same with the Treasurer of the United States. Organization Order No. 121 was revoked by Organization Order No. 3, dated December 13, 1967, Part IVC of which prescribed the functions of the Finance Office within a newly established Department of General Administration. The executive functions of

the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. Functions of the Finance Office as stated in Part IVC of Organization Order No. 3 were transferred to the Director of the Department of Finance and Revenue by Commissioner's Order No. 69-96, dated March 7, 1969. The collection functions of the Director of the Department of Finance and Revenue were transferred to the District of Columbia Treasurer by § 47-316 on March 5, 1981.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5201.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of

Columbia and its Various Forms of Governmental Organization in Volume 1). Section 402(269) of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to the District of Columbia Council, subject to the right of the Commissioner as provided in § 406 of the Plan. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

CASE NOTES

ANALYSIS

Fraternal benefit associations.
Government service associations.
Insurance.
Licensing.
Rules and regulations.

Fraternal benefit associations.

Where metropolitan police retiring association was incorporated as a charitable organization, membership was limited to members of metropolitan police department, the White House police, and park police, purpose of association was to furnish financial relief to members in case of their retirement from police force, and payments upon retirement were principally the amounts of retirees' own contributions with some increment of interest from investments which were required to be approved by majority of board of directors and by majority vote of membership in regular session, association was not engaged in "insurance" and hence was not required to obtain certificate of authority from Superintendent of Insurance. D.C. Code 1961, §§ 29-601, 35-101, 35-102, 35-105, 35-202, 35-404, 35-1305, 35-1320, 35-1321. *Metropolitan Police Retiring Ass'n v. Tobriner*, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

Government service associations.

A group health association incorporated as a non-profit relief association to furnish medical service and supplies in variable degrees within specified limitations to its members who make regular limited payments and are composed solely of civil employees of the executive branch of the United States government service, is not within the purview of laws of the District of

Columbia relating to insurance or to organizations providing for the payment of indemnity on account of sickness or accident, particularly in view of provision in by-law that association should not be liable to its members or their dependents for any act of omission or commission on the part of physicians or other persons with whom it may contract for the rendition of services to them. D.C. Code 1929, T. 5, §§ 121-126, 172, 173, 176, 178, 179, 184-215; D.C. Code Supp. III, 1937, T. 20, § 966. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

A group health association incorporated as a non-profit relief association to furnish medical service and supplies in variable degrees within specified limitations to its members who make regular limited payments and are composed solely of civil employees of the executive branch of the United States government service, including employees of the Home Owners' Loan Corporation, falls within provisions of statutes exempting from provisions relating to regulations, licensing, and control of insurance companies, relief associations not conducted for profit composed solely of officers and enlisted men of the army or navy, or solely of employees of any other branch of the United States government service, or solely of employees of any individual company, firm, or corporation, since for purposes of exemption, employees of Home Owners' Loan Corporation should be held to be employees of the executive department. D.C. Code 1929, T. 5, §§ 121-126, 179; D.C. Code Supp. III, 1937, T. 20, § 966, subsec. 8. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

The word "corporation" as used in provisions of statutes exempting from provisions relating

to regulation, licensing, and control of insurance companies, relief associations not conducted for profit composed solely of officers and enlisted men of the army or navy, or solely of employees of any other branch of the United States government service, or solely of employees of any individual company, firm, or corporation refers to private concerns and not to governmental agencies, particularly if they are included within preceding classifications. D.C. Code 1929, T. 5, §§ 121-126, 179; D.C. Code Supp. III, 1937, T. 20, § 966, subsec. 8. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

The Superintendent of Insurance for the District of Columbia had no standing to challenge generally and without regard to features of insurance or indemnity the validity of the incorporation of a group health association incorporated as a non-profit corporation to furnish medical service and supplies in variable degrees within specified limitations to its members who make regular limited payments and are composed solely of civil employees of the executive branch of the United States government service. D.C. Code 1929, T. 5, §§ 121-126. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

Insurance.

When purposes for which statutory regulations of insurance in District of Columbia were enacted have no significance in a particular situation, that serves as a guide in determining whether a particular activity is not within the regulations. D.C. Code 1961, §§ 35-102, 35-105, 35-202, 35-1320, 35-1321. *Metropolitan Police Retiring Ass'n v. Tobriner*, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

"Insurance" involves distribution of a risk, and whether a contract is one of "insurance" or of "indemnity", each involves contractual security against anticipated loss, and there must be a risk of loss to which one party may be subjected by contingent or future events and an assumption of it by legally binding arrangement by another. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

The question whether an arrangement is one of insurance within the laws of the District of Columbia relating to insurance companies turns not on whether risk is involved or assumed but on whether that or something else to which it is related in the particular plan is its principal object and purpose. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

In determining whether a group health association was engaged in the business of insurance in the District of Columbia in violation of law and was within the purview of laws relating to insurance companies, the court was con-

cerned with the plan as a whole and not with artificially segregated single phases of the plan. *Jordan v. Group Health Ass'n*, 107 F.2d 239, 1939 U.S. App. LEXIS 4670 (1939).

A "mutual insurance company" is one in which the members are both the insurers and the insured, sometimes through a fund made up of cash premiums or of premium notes, and sometimes by assessment laid on all members, whereas the purpose of "stock insurance company" is primarily to earn money for the stockholders. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

Under District of Columbia Insurance Code, mutual insurance company can obtain a license and do business if it has an organization and maintains thereafter a surplus of \$10,000 and a fund in excess of its present liabilities equal to premium advances, which shall not be less than \$10,000. D.C. Code 1929, T. 5, § 187. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

Where an organization agreed to pay a non-profit District of Columbia corporation a fixed sum and the corporation agreed to provide complete medical service for a fixed period to the organization's employees who would join the corporation, the corporation was not engaged in "business of insurance" in violation of law, since the statute of the District of Columbia providing that every corporation which collects dues from its members and which provides for payment of indemnity on account of sickness, etc., shall be known as "health, accident and life insurance companies," does not include necessarily contracts to indemnify, but is limited to those which provide for payment of indemnity, the word "payment" as ordinarily used, meaning the payment of money. D.C. Code 1929, T. 5, § 179; T. 20 §§ 121, 122. *Group Health Ass'n v. Moor*, 24 F.Supp. 445, 1938 U.S. Dist. LEXIS 1961 (D.D.C.1938).

Licensing.

The absence of a profit motive and facts that metropolitan police retiring association possesses a representative government and engages in no solicitation of the public, add some though not controlling support to view that its activities are not within scope of statute primarily designed to protect insured vis-a-vis the insurer. D.C. Code 1961, §§ 35-102, 35-105, 35-202, 35-1320, 35-1321. *Metropolitan Police Retiring Ass'n v. Tobriner*, 306 F.2d 775, 1962 U.S. App. LEXIS 4731 (C.A.D.C. 1962).

Rules and regulations.

A District of Columbia mutual insurance company could enjoin superintendent of insurance of District of Columbia from enforcing void rules of superintendent regulating reserves,

costs of operation, declaration of dividends and payment of salaries and fees by mutual insurance companies writing taxicab insurance, and from canceling company's license for failure to obey such regulations. Act June 29, 1938, 52 Stat. 1233; D.C. Code 1929, T. 5, § 171 et seq. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

The words "write insurance" and "fix maximum rates" in Taxicab Act authorizing superintendent of insurance of District of Columbia to make rules relating to writing of taxicab insurance and fixing of maximum rates authorized superintendent to control solicitation of insurance, terms and conditions of contract, rates to be charged and enforcement of provisions of the act and the general insurance law, and enabled superintendent to prohibit unreasonable commissions to agents. Act June 29, 1938, 52 Stat. 1233. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

Rules of superintendent of insurance of District of Columbia requiring companies writing taxicab insurance to collect premiums in advance and to give Public Utilities Commission five days' notice of cancellation of policies and to keep complete records of accidents, claims and suits and to make payments by company check, and to keep record of policies issued and lapsed, and to collect no charge or policy fee in addition to premium are valid as being in furtherance of declared policy of Taxicab Act to fix maximum rates and to make taxicab insurance compulsory. Act June 29, 1938, 52 Stat. 1233. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

Rules of superintendent of insurance of District of Columbia regulating reserves, costs of operation, declaration of dividends and payment of salaries and fees by mutual insurance companies writing taxicab insurance were invalid as not within the authority of superintendent. Act June 29, 1938, 52 Stat. 1233; D.C. Code 1929, T. 5, § 171 et seq. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

In absence of statutory authority, superintendent of insurance of District of Columbia cannot add to, amend, or alter insurance law by regulations, but can only make rules consistent with the provisions of such law. D.C. Code 1929, T. 5, § 171 et seq. *Hutchins Mut. Ins. Co. of*

District of Columbia v. Hazen, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

A rule of superintendent of insurance of District of Columbia forbidding company writing taxicab insurance to promise to pay dividend or reward to any policyholder unless approved by superintendent was proper on ground that promise to pay dividends was equivalent to rebate, but not to extent of authorizing superintendent to control payment of reasonable dividends when declared out of earnings in ordinary course of business. Act June 29, 1938, 52 Stat. 1233. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

A rule of superintendent of insurance of District of Columbia authorizing superintendent to withdraw certification of company writing taxicab insurance for failure to comply with regulations applicable to such companies was invalid as an assumption of power nowhere extended and as contrary to rights to trial and conviction before imposition of such drastic penalty. Act June 29, 1938, 52 Stat. 1233. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

The general insurance law of District of Columbia does not give the superintendent of insurance of the District the power to make regulations governing in the minutest detail the operation and business of an insurance company. D.C. Code 1929, T. 5, § 171 et seq. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

A rule of the superintendent of insurance of District of Columbia applicable to companies writing taxicab insurance, defining rebating and calling attention to prohibition against rebating, was valid under provision of District of Columbia Insurance Code prohibiting rebating. D.C. Code 1929 T. 5, § 180. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

Rules of superintendent of insurance of District of Columbia providing that taxicab insurance policies must be in a form approved by superintendent are valid as being in furtherance of provision of Compulsory Taxicab Insurance Act that taxicab insurance must be "in such form and on such terms or conditions" as the Public Utilities Commission may direct. Act June 29, 1938, 52 Stat. 1233. *Hutchins Mut. Ins. Co. of District of Columbia v. Hazen*, 105 F.2d 53, 1939 U.S. App. LEXIS 4736 (1939).

§ 31-5203. Copy of application by insured to be delivered with policy.

Each life insurance company, benefit order, and association doing a life insurance business in the District of Columbia shall deliver with each policy

issued by it a copy of the application made by the insured so that the whole contract may appear in said application and policy, in default of which no defense shall be allowed to such policy on account of anything contained in, or omitted from, such application.

(Mar. 3, 1901, 31 Stat. 1294, ch. 854, § 657; June 30, 1902, 32 Stat. 534, ch. 1329.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Industrial life insurance policies, proof of

fraud etc., with reference to requirements of this section, see § 31-4802.

Prior Codifications. — 1981 Ed., § 35-203. 1973 Ed., § 35-203.

CASE NOTES

ANALYSIS

Applications.

—Delivery of applications.

—In general.

Construction and application.

Contracts.

Defenses.

Renewal of policies.

Applications.

— Delivery of applications.

Under provisions that policy constituted entire agreement, and that insurer might avoid policy if insured was in unsound health excluding evidence respecting insured's unsound health when policy was issued held error, though insurer failed to deliver copy of alleged application with policy. D.C. Code 1929, T. 5, § 183. *Washington Fidelity Nat. Ins. Co. v. Burton*, 53 S.Ct. 26, 1932 U.S. LEXIS 8 (U.S. Dist. Col. 1932).

Where a life policy by its terms constitutes the entire agreement, the statute requiring a copy of the application to be delivered with each life policy issued by an insurer does not prevent an insurer from basing a defense on a policy provision stating that if within two years of date of issue insured has received treatment or has been attended by any physician for any serious disease, the policy should be voidable unless reference to such treatment is endorsed on the policy, even though the policy was issued on a written application and no copy of the application was delivered with the policy. D.C. Code 1929, T. 5, § 183. *Pullen v. Sun Life Ins. Co. of America*, 121 F.2d 110, 1941 U.S. App. LEXIS 3170 (1941).

Where written application, if there was one, was not delivered with industrial life policy, but policy by its terms constituted the entire agreement, the statute requiring a copy of the application to be delivered with each life policy issued by an insurer did not prevent insurer from making any defense that it had under the

terms of the policy. D.C. Code 1929, T. 5, § 183. *Pullen v. Sun Life Ins. Co. of America*, 121 F.2d 110, 1941 U.S. App. LEXIS 3170 (1941).

Under section 657 of the Code, D.C. Code 1929, T. 5, § 183, defense that insured misstated his age is not available to a grand lodge of the Brotherhood of Railroad Trainmen in an action on a certificate, where the application was not attached to the certificate, nor a copy of it delivered with the certificate or at any other time. *Grand Lodge of Brotherhood of Railroad Trainmen v. Groves*, 48 App.D.C. 151, 1918 U.S. App. LEXIS 2369 (1918).

While Code of Law 1901, § 657, 32 Stat. 534, c. 1329, requiring insurance companies to deliver, with every policy issued, a copy of the application made by the insured, so that the whole contract may appear in the application and policy, is to be strictly construed, a mere preliminary statement made to the company by its agent and which he alone signs is not a part of the contract of insurance, and need not be delivered with the policy. *Griffith v. Metropolitan Life Ins. Co. of New York*, 36 App.D.C. 8, 1910 U.S. App. LEXIS 5943 (1910).

Under section 657, Code D.C., 31 Stat. 1294, c. 854, providing that no defense shall be allowed on a policy of life insurance unless the insurer deliver with the policy a copy of the application made by the insured, it is necessary that a copy of the entire application be delivered with the policy; it not being left to the discretion of the insurer to select such parts of the application as it may deem material for delivery with the policy. *Metropolitan Life Ins. Co. v. Hawkins*, 31 App.D.C. 493, 1908 U.S. App. LEXIS 5654 (1908).

— In general.

Statute requiring copy of "application" to be delivered with policy refers to writings, not oral applications. D.C. Code, 1929, T. 5, § 183. *Washington Fidelity Nat. Ins. Co. v. Burton*, 53 S.Ct. 26, 1932 U.S. LEXIS 8 (U.S. Dist. Col. 1932).

Statute requiring copy of application to be delivered with policy does not make written application obligatory. D.C. Code 1929, T. 5, § 183. *Washington Fidelity Nat. Ins. Co. v. Burton*, 53 S.Ct. 26, 1932 U.S. LEXIS 8 (U.S. Dist. Col. 1932).

In light of fact that medical authorization form signed by insured did not contain or call for any information, failure to attach the form to life policy was immaterial and did not bring into play bar of statute requiring an insurance company to include with issued policy a copy of application made by insured, or preclude insurer from defending on ground of insured's failure to disclose his medical history. D.C. Code § 35-203. *Blair v. Prudential Ins. Co.*, 472 F.2d 1356, 1972 U.S. App. LEXIS 6094 (C.A.D.C. 1972).

That insured did not undergo medical examination or make accompanying representations relating to physical condition at time of application for second life insurance policy held not, under facts shown, to defeat insurer's right to defend on ground of fraudulent representations in application for previous policy made part of second policy. D.C. Code 1929, T. 5, § 183. *Northwestern Mut. Life Ins. Co. v. Gott*, 68 F.2d 426, 1933 U.S. App. LEXIS 4976 (1933).

The accuracy of the copy of one part of an application for insurance attached to the policy cannot be for the first time challenged on appeal by the beneficiary, where on the trial her counsel conceded the copy was an exact copy of that part of the original application, and stated that her only contention was that, because of the failure of the insured to attach another part of the application to the policy, the whole application was not delivered with the policy as required by Code of Laws 1901, § 657, and it also appears that, under the circumstances, the insurer could have had no motive in attaching an inaccurate copy of the application to the policy. *Griffith v. Metropolitan Life Ins. Co. of New York*, 36 App.D.C. 8, 1910 U.S. App. LEXIS 5943 (1910).

Where the insured in an application for life insurance agrees that the answers to questions therein shall be taken as warranties, and that, if not true, the policy shall be void, a representation in the application that the insured had not been attended for a year by any other physician than one named, when, in fact, she had within two days been attended and treated by another physician for a very serious affliction, constitutes a suppression of a material fact amounting to a misrepresentation and breach of warranty, and precludes a recovery on the policy. *Griffith v. Metropolitan Life Ins. Co. of New York*, 36 App.D.C. 8, 1910 U.S. App. LEXIS 5943 (1910).

Where voidability provision of life policy required company to prove that applicant had received medical treatment, but insurer did not

attach written application, if any, to policy, insurer could not defend on account of anything contained in or omitted from application, and was barred from declaring policy void on account of alleged nondisclosure in application. D.C. Code 1951, § 35-203. *Walton v. Sun Life Ins. Co.*, 115 A.2d 310, 1955 D.C. App. LEXIS 187 (Cr.App. 1955).

Construction and application.

Statute requiring an insurance company to include with issued policy a copy of application made by insured was enacted for protection of insured, not the insurance company. D.C. Code § 35-203. *Blair v. Prudential Ins. Co.*, 472 F.2d 1356, 1972 U.S. App. LEXIS 6094 (C.A.D.C. 1972).

Code D.C. § 657, requiring a copy of every application for life insurance to be delivered with the policy, being enacted to furnish the insured with a copy of the application upon the representations in which the validity of the policy and its binding force may be made to depend, was intended to remedy a mischief, and is to be given a reasonably liberal interpretation to that end. *Metropolitan Life Ins. Co. v. Burch*, 39 App.D.C. 397, 1912 U.S. App. LEXIS 2243 (1912).

Contracts.

Under District of Columbia law, an insurance policy is a contract whose construction is based on its language. *Nationwide Mut. Ins. Co. v. Richardson*, 270 F.3d 948, 2001 U.S. App. LEXIS 23724 (C.A.D.C. 2001).

Under District of Columbia law, because insurers draft insurance contracts with the help of experts and lawyers, unless the language of an insurance policy's exclusion is unambiguous, doubts are to be resolved in favor of the insured. *Nationwide Mut. Ins. Co. v. Richardson*, 270 F.3d 948, 2001 U.S. App. LEXIS 23724 (C.A.D.C. 2001).

Under District of Columbia law, if insurance agreement is unambiguous, court will apply plain language used and should not consider extrinsic evidence as to how to interpret policy. *Cambridge Holdings Group, Inc. v. Fed. Ins. Co.*, 357 F.Supp.2d 89, 2004 U.S. Dist. LEXIS 27009 (2004), appeal dismissed by 489 F.3d 1356, 376 U.S. App. D.C. 520, 2007 U.S. App. LEXIS 14360, 67 Fed. R. Serv. 3d (Callaghan) 1397 (2007).

Defenses.

In action on industrial life policy declaring that it expressed the entire agreement between the parties, a defense open to insurer if no written application existed was not precluded by the statute and the insurer could defend on violation of policy provisions having no relation to the application. D.C. Code 1951, § 35-203. *Ferguson v. Quaker City Life Ins. Co.*, 129 A.2d 189, 1957 D.C. App. LEXIS 201 (Cr.App. 1957).

Where insurer sets up defense of insured's unsound health prior to issuance of policy, whether defense is based on application or on policy provision, insurer has burden of proving that applicant or insured acted in bad faith. D.C. Code 1951, §§ 35-203, 35-1002. *Walton v. Sun Life Ins. Co.*, 115 A.2d 310, 1955 D.C. App. LEXIS 187 (Cr.App. 1955).

Renewal of policies.

Code D.C. § 657, providing that each insurance company doing a life insurance business in the District of Columbia shall deliver with each policy a copy of the application made by

insured, so that the whole contract may appear in said application and policy, in default of which no defense shall be allowed to such policy on account of anything contained in or omitted from, such application, as amended by Act June 30, 1902, D.C. Code 1929, T. 5, § 183, applies to an application for the renewal of a lapsed policy as well as to one for the original policy; and there is no error in excluding from the evidence a renewal application a copy of which was not so delivered. *Metropolitan Life Ins. Co. v. Burch*, 39 App.D.C. 397, 1912 U.S. App. LEXIS 2243 (1912).

§ 31-5204. Principal office and books, records, and files of corporation to be in District; exception; reincorporation of certain corporations; violations; prosecutions.

(a) Any corporation now or hereafter formed or organized under any provision of law in force and effect in the District of Columbia to engage in an insurance business shall maintain its principal office within said District and shall keep its books, records, and files therein, and shall not remove from said District either its principal office or its books, records, or files without the permission of the Mayor of the District of Columbia first had and obtained; provided, however, that nothing contained in this section shall be construed to apply to the books, records, and files of any such corporation kept in a branch office agency of such corporation, which books, records, and files relate solely to the business transacted by the said branch office agency; and provided further, that any insurance corporation created by special act of Congress is authorized upon resolution of its board of directors or trustees to reincorporate under the laws of any state of the United States, a certified copy of such resolution of such board of directors or trustees having first been filed in the Office of the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] of the District of Columbia and recorded in the Office of the Recorder of Deeds of the District of Columbia. Upon compliance with the above conditions, the assets of the said corporation shall thereby become vested in the new corporation. Said new corporation shall faithfully carry out any and every right, obligation, and liability of said original corporation.

(b) Any corporation violating any of the provisions of this section shall forthwith forfeit its charter, which forfeiture shall operate as a revocation of its license to do business within said District.

(c) Any officer, agent, or employee of any such corporation who shall violate any of the provisions of this section shall be guilty of a misdemeanor and upon conviction shall pay a fine of not less than \$300 or be imprisoned for not more than 90 days, or by both such fine and imprisonment. All prosecutions under this section shall be upon information filed in the Superior Court of the District of Columbia in the name of the District of Columbia by the Corporation Counsel thereof or any of his assistants.

(Mar. 3, 1901, ch. 854, § 657a; May 17, 1932, 47 Stat. 158, ch. 189; Apr. 1, 1942, 56 Stat. 190, ch. 207, § 1; July 8, 1963, 77 Stat. 77, Pub. L. 88-60, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); May 21, 1997, D.C. Law 11-268, § 10(d), 44 DCR 1730.)

Cross references. — Hospital and medical services corporations, applicability of this section, see § 31-3503.

Managing general agent records, retention, see § 31-1503.

Prior Codifications. — 1981 Ed., § 35-204. 1973 Ed., § 35-204.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5201.

Editor's notes. — Delegation of functions: Reorganization Order No. 43, Part VIII, dated June 23, 1953, delegated to the Superintendent of Insurance the function of granting or denying permission to remove from the District of Columbia the principal office, books, records, and files of an insurance company, as set forth in subsection (a) of this section.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5201.

Change in Government. — This section

originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner. The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11), abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5205. Employees' compensation corporations or associations to file certain information with Commissioner; disapproval of premium rate or schedule; judicial review.

Every insurance corporation or association authorized to transact business in the District of Columbia, which insures employers against liability for compensation under the Employees' Compensation Act, shall file with the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] its manual of classifications and underwriting rules, together with basic rates for each class, and also merit rating plans designed to modify the class rates, none of which shall take effect until the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] shall have approved the same as adequate and reasonable for the group of risks to which they respectively apply. The Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] may withdraw his approval of any premium rate or schedule made by any insurance corporation or association, if, in his judgment, such premium rate or schedule is inadequate or unreasonable; provided, that upon petition of the company or association or any other party aggrieved the opinion of the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking] shall be subject to review by the Superior Court of the District of Columbia: Provided further, that any petition for review shall be

filed with said Court within 30 days after the rendition of opinion by the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking].

(Mar. 3, 1901, ch. 854, § 657b; April 16, 1934, 48 Stat. 592, ch. 144; June 25, 1936, 49 Stat. 1921, ch. 804; June 25, 1948, 62 Stat. 991, ch. 646, § 32(b); May 24, 1949, 63 Stat. 107, ch. 139, § 127; July 29, 1970, 84 Stat. 572, Pub. L. 91-358, title I, § 155(c)(36); May 21, 1997, D.C. Law 11-268, § 10(d), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-205. 1973 Ed., § 35-205.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5201.

References in text. — “The Employees’

Compensation Act,” referred to near the beginning of the first sentence, refers to Chapter 15 of Title 36.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5201.

SUBTITLE VIII-A. CERTIFIED CAPITAL INVESTMENT BY
INSURANCE COMPANIES.

CHAPTER 52A. CERTIFIED CAPITAL COMPANIES.

Sec.	Sec.
31-5231. Definitions.	31-5237. Decertification.
31-5232. Certification.	31-5238. Transferability.
31-5233. Premium Tax Credit.	31-5238.01. Fees deposited in Insurance Regulatory Trust Fund.
31-5234. Aggregate limitations on Premium Tax Credits; Premium Tax Credit Allocation Requests.	31-5238.02. Compliance and economic impact.
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§ 31-5231. Definitions.

For the purpose of this chapter, the term:

(1) "Affiliate" means:

(A) Any person, directly or indirectly, beneficially owning (whether through rights, options, convertible interests, or otherwise), controlling, or holding power to vote 15% or more of the outstanding voting securities or other voting ownership interests of the Certified Capital Company or Certified Investor;

(B) Any person with 15% or more of its outstanding voting securities or other voting ownership interests directly or indirectly beneficially owned (whether through rights, options, convertible interests, or otherwise), controlled, or held with power to vote by the Certified Capital Company or Certified Investor;

(C) Any person directly or indirectly controlling, controlled by, or under common control with the Certified Capital Company or Certified Investor;

(D) A partnership or limited liability company in which the Certified Capital Company or Certified Investor is a general partner, manager, or managing member; or

(E) Any person who is an officer, director, employee, or agent of the Certified Capital Company or Certified Investor or an immediate family member of the officer, director, employee, or agent.

(2) "Allocation Date" means the date on which the Certified Investors of a Certified Capital Company are allocated Premium Tax Credits by the Commissioner under § 31-5234.

(3) "Certified Capital" means an investment of cash by a Certified Investor in a Certified Capital Company that fully funds the purchase price of an equity interest in the Certified Capital Company, a Qualified Debt Instrument, or a combination of the two.

(4) "Certified Capital Company" means a partnership, corporation, trust, or limited liability company, whether organized on a profit or not for profit basis, that has as its primary business activity the investment of cash in Qualified Businesses and that is certified by the Commissioner as meeting the criteria of this chapter.

(5) “Certified Investor” means any insurance company, approved by the Commissioner, that invests Certified Capital pursuant to an allocation of Premium Tax Credits under § 31-5234.

(6) “Commissioner” means the Commissioner of Insurance and Securities Regulation [Commissioner of the Department of Insurance, Securities, and Banking].

(7) “District” means the District of Columbia.

(8) “District Premium Tax Liability” means any liability incurred by an insurance company under § 31-205 or, in the case of a repeal or reduction by the District of the tax imposed by § 31-205, any other tax liability incurred by an insurance company under District law.

(8A) “Economic Impact Study” means an assessment of the performance of the Certified Capital Company program that includes:

(A) Job growth and retention in Qualified Businesses after the receipt of Qualified Investments, with reference to the following measures:

(i) Overall number of jobs created and retained;

(ii) Number of jobs created and retained in Tier One Qualified Businesses, Tier Two Qualified Businesses, and Tier Three Qualified Businesses; and

(iii) A description of whether the jobs are full-time salaried, full-time hourly, part-time, or contract;

(B) Estimates of the taxation revenue generated as the result of Qualified Investments, with specific reference to income tax, sales tax, and corporate tax; and

(C) Comparison of each of the measures set forth in subparagraphs (A) and (B) of this paragraph among all Certified Capital Companies.

(8B) “Follow-on Investment” means any Qualified Investment that a Certified Capital Company makes in a Qualified Business that is subsequent to its Initial Investment in that Qualified Business.

(8C) “Initial Investment” means the 1st Qualified Investment that a Certified Capital Company makes in a Qualified Business after May 27, 2010.

(9) “Person” means any natural person or entity, including a corporation, general or limited partnership, trust, or limited liability company.

(10) “Premium Tax Credit” means a tax credit which may be applied against a Certified Investor’s District Premium Tax Liability under § 31-5233.

(11) “Premium Tax Credit Allocation Request” means an application for allocation of Premium Tax Credits prepared and executed by a Certified Investor on a form provided by the Commissioner and filed by a Certified Capital Company with the Commissioner.

(11A) “Principal Business Operations” means the location where a business conducts its primary business activities, its managers and the majority of its employees work, and its material books and records are maintained.

(12)(A) “Qualified Business” means a business, except as provided in subparagraph (B) of this paragraph, that meets the following qualifications as of the time of a Certified Capital Company’s Initial Investment in the business:

(i)(I) It is headquartered in the District, its Principal Business Operations are located in the District, and the Qualified Investment it receives

is used solely to support its business operations in the District, except for advertising, promotions, and sales purposes; or

(II) It is headquartered and has its Principal Business Operations located outside the District, certifies in an affidavit that the business will relocate its headquarters and its Principal Business Operations to the District within 90 days after its receipt of the Initial Investment by the Certified Capital Company, and the Qualified Investment it receives is used solely to support its business operations in the District, except for advertising, promotions, and sales purposes;

(ii) At least 25% of its employees are residents of the District;

(iii) At least 75% of its employees are employed in the District;

(iv) It is a small business concern as defined in 13 C.F.R. § 121.201;

(v) It certifies in an affidavit that the business is unable to obtain conventional financing, which means that the business has failed in an attempt to obtain funding for a loan from a bank or other commercial lender or that the business cannot reasonably be expected to qualify for financing under the standards of commercial lending;

(vi) The business was not organized by a Certified Capital Company or an affiliate of a Certified Capital Company; provided, that this sub-subparagraph shall not prohibit a Certified Capital Company from providing financial, technical, or similar advice to a business before making an investment in such business;

(vii) The business does not have an ownership interest, investment interest, compensation agreement, or similar financial relationship with a Certified Capital Company or any affiliate of a Certified Capital Company before the date on which a Certified Capital Company makes an Initial Investment in the business; provided, that this sub-subparagraph shall not prohibit a Certified Capital Company from providing financial, technical or similar advice to a business before making an investment in such business.

(B) A business shall not be a Qualified Business if it is:

(i) A regional or national franchise;

(ii) Primarily engaged in real estate development or leasing projects;

(iii) Primarily engaged in insurance; or

(iv) Engaged in the provision of professional services by accountants, lawyers, or physicians.

(13) "Qualified Debt Instrument" means a debt instrument issued to a Certified Investor by a Certified Capital Company, at par value or a premium, with an original maturity date of at least 5 years from date of issuance and a repayment schedule which is no faster than a level principal amortization over 5 years, which does not permit the Certified Investor to receive prepayment of interest, and which contains no interest, distribution, or payment features which are related to the profitability of the issuing Certified Capital Company or the performance of its investment portfolio.

(14) "Qualified Distribution" means any distribution or payment of a Certified Capital Company in connection with the following:

(A) Reasonable costs and expenses of forming and syndicating the Certified Capital Company, which may include the costs of financing and

insuring the obligations of the Certified Capital Company; provided, that no more than one Certified Investor, or the Affiliates thereof, in the Certified Capital Company may receive a Qualified Distribution related to providing a guaranty, indemnity, bond, insurance policy, or other payment undertaking in favor of all of the Certified Investors;

(B) Reasonable costs and expenses of managing and operating the Certified Capital Company, including reasonable and necessary fees paid for professional services (such as legal and accounting services) related to the formation and operation of the Certified Capital Company and an annual management fee in an amount that does not exceed 2½% of the Certified Capital of the Certified Capital Company; and

(C) Any projected increase in federal or state taxes of the direct or indirect equity holders of a Certified Capital Company resulting from the earnings or other tax liability of the Certified Capital Company to the extent that the increase is related to the direct or indirect ownership of a Certified Capital Company.

(15) "Qualified Investment" means the investment of cash by a Certified Capital Company in a Qualified Business for the purchase of any debt, debt participation, equity, or hybrid security, of any nature and description, including a debt instrument or security which has the characteristics of debt but which provides for conversion into equity or equity participation instruments, such as options or warrants; provided, that:

(A) Any such debt instrument shall have a maturity of at least 24 months from the date the debt is incurred; and

(B) A Certified Capital Company, after an investment and assuming the conversion and exercise of any equity participation or hybrid security, shall not own more than 49% of the voting equity of the Qualified Business.

(16) "Tier One Qualified Business" means any Qualified Business:

(A) That did not receive a Qualified Investment prior to May 27, 2010;

(B) That is engaged in one of the following lines of business as its primary line of business:

- (i) Healthcare services;
- (ii) Information technology;
- (iii) Environmental services/technology;
- (iv) Internet information providers;
- (v) Communication services;
- (vi) Biotechnology/research services;
- (vii) Multimedia/graphics software;
- (viii) Business management services;
- (ix) Financial services; or
- (x) Restaurant services; and

(C) Whose Principal Business Operations are located within:

(i) A Neighborhood Investment Program target area designated pursuant to § 6-1073; or

(ii) The District of Columbia Enterprise Zone as defined by section 1400 of the Internal Revenue Code of 1986, approved August 5, 1997 (111 Stat. 863; 26 U.S.C. § 1400).

(17) "Tier Two Qualified Business" means any Qualified Business that did not receive a Qualified Investment prior to May 27, 2010, that is not a Tier One Qualified Business, and that is engaged in one of the lines of business set forth in paragraph (16)(B)(i) through (x) of this section as its primary line of business.

(18) "Tier Three Qualified Business" means any Qualified Business that did not receive a Qualified Investment prior to May 27, 2010, and that is not a Tier One Qualified Business or a Tier Two Qualified Business.

(Mar. 10, 2004, D.C. Law 15-87, § 2, 50 DCR 10982; Apr. 13, 2005, D.C. Law 15-354, § 49(a), 52 DCR 2638; May 27, 2010, D.C. Law 18-181, § 2(a), 57 DCR 3388.)

Effect of amendments. — D.C. Law 15-354, in par. (8), validated previously made technical corrections.

D.C. Law 18-181 added pars. (8A), (8B), (8C), (11A), and (16) to (18); and rewrote pars. (12) and (15).

Legislative history of Law 15-87. — Law 15-87, the "Certified Capital Companies Act of 2003", was introduced in Council and assigned Bill No. 15-20, which was referred to Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on July 8, 2003, and November 4, 2003, respectively. Signed by the Mayor on November 25, 2003, it was assigned Act No. 15-254 and transmitted to both Houses of Congress for its review. D.C. Law 15-87 became effective on March 10, 2004.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 18-181. — Law 18-181, the "Certified Capital Companies Amendment Act of 2010", was introduced in Council and assigned Bill No. 18-402, which was referred to the Committee on Public Services and Consumer Affairs. The bill was adopted on first and second readings on March 2, 2010, and March 16, 2010, respectively. Signed by the Mayor on April 7, 2010, it was assigned Act No. 18-378 and transmitted to both Houses of Congress for its review. D.C. Law 18-181 became effective on May 27, 2010.

Editor's notes. — Section 3 of D.C. Law 18-181 provided: "Sec. 3. Applicability. This act shall not apply to any Qualified Investment or distribution made by any Certified Capital Company prior to the effective date of this act."

§ 31-5232. Certification.

(a) The Commissioner shall begin accepting applications for certification as a Certified Capital Company not later than 150 days after March 10, 2004. An applicant for certification as a Certified Capital Company shall pay a nonrefundable application fee of \$15,000 at the time of filing the application with the Commissioner. The Commissioner shall establish by rule or regulation the procedures for making an application for certification as a Certified Capital Company.

(b) From the time of the application to the time of allocation of Premium Tax Credits, the applicant shall have equity capitalization of at least \$500,000 that must be in the form of unencumbered cash, marketable securities, or other liquid assets.

(c) The Commissioner shall review the organizational documents of each applicant for certification and the business history of the applicant and shall determine whether the applicant's cash, marketable securities, and other liquid assets meet the requirements of subsection (b) of this section. As part of its application, each applicant shall submit to the Commissioner its balance sheet, audited with an unqualified opinion of an independent certified public

accountants, that is dated no earlier than 35 days prior to the date the application is filed under subsection (a) of this section.

(d) The applicant shall certify that the Certified Capital Company does or will, following certification, maintain its principal office within the District and shall commit to maintain a set of its books, records, files, and any other information required by the Commissioner as a condition of certification or as required by rule or regulation.

(e) The Commissioner shall verify that at least 2 principals of the Certified Capital Company or at least 2 persons employed or engaged to manage the funds of the Certified Capital Company each have 3 or more years of experience in the venture capital industry.

(f) Any offering material involving the sale of securities of the Certified Capital Company shall include the following statement:

“By authorizing the formation of a Certified Capital Company, the District of Columbia does not necessarily endorse the quality of management or the potential for earnings of such company and is not liable for any damages or losses to any investor in the company. Use of the word ‘certified’ in any offering material does not constitute a recommendation or endorsement of the investment by the District of Columbia, its officers, employees, or agents. Upon a violation of the Certified Capital Companies Act of 2003 [Chapter 52A of Title 31 of the D.C. Official Code, § 31-5231 et seq.], the District of Columbia may require forfeiture of unused Premium Tax Credits and repayment of used Premium Tax Credits.”

(g) Within 30 days of receipt of a complete application, the Commissioner shall issue the certification or shall provide the applicant with notice of the disapproval of the certification that shall communicate in detail to the applicant the grounds for the refusal, including suggestions for curing any defects in the application. If an applicant submits an amended application within 15 days of receipt of refusal by the Commissioner, the Commissioner shall have 15 days from the receipt of the complete amended application by which to communicate its approval or refusal of the amended application to the applicant. The Commissioner shall review and approve or reject applications in the order complete applications are received.

(h) No insurance company or any Affiliate of an insurance company shall, directly or indirectly, own (whether through rights, options, convertible interests, or otherwise) 15% or more of the voting equity interests, or other voting ownership interests of or manage a Certified Capital Company or control the direction of investments for a Certified Capital Company. This provision shall not preclude a Certified Investor, insurance company, or any other person from exercising its legal rights and remedies (which may include interim management of a Certified Capital Company): (1) if a Certified Capital Company is in default of its statutory obligations or its contractual obligations to the Certified Investor, insurance company, or other person; or (2) otherwise insure that the Certified Capital Company satisfies the requirements of § 31-5235. Nothing in this section shall limit an insurance company’s ownership of nonvoting equity securities or other nonvoting ownership interests of the Certified Capital Company.

(Mar. 10, 2004, D.C. Law 15-87, § 3, 50 DCR 10982.)

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

§ 31-5233. Premium Tax Credit.

(a) Any Certified Investor who makes an investment of Certified Capital pursuant to an allocation of Premium Tax Credits under § 31-5234 shall, in the year of investment, earn a Premium Tax Credit in the amount of the Certified Investor's investment of Certified Capital.

(b) A Certified Investor may claim an amount not to exceed 25% of the Premium Tax Credits per year ("Annual Amount") against its District Premium Tax Liability, beginning with the premium tax filing for calendar year 2009. The Annual Amount shall not exceed the District Premium Tax Liability of the Certified Investor for the taxable year. All unused Premium Tax Credits may be carried forward indefinitely until they are utilized.

(c)(1) A Certified Investor may use up to ½ of its Annual Amount to offset its required June 1st payment of ½ of an insurance company's District Premium Tax Liability, as set forth under § 31-205(b)(4), beginning with the June 1, 2008 payment.

(2) A Certified Investor claiming a Premium Tax Credit shall not be required to pay any additional or retaliatory tax levied pursuant to § 31-205(f)(1) as a result of claiming the Premium Tax Credit.

(d) A Certified Investor shall not be required to reduce the amount of premium tax included by the Certified Investor in connection with ratemaking in the District, for any insurance written by the Certified Investor or affiliate thereof, because of a reduction in the Certified Investor's District Premium Tax Liability from the utilization of the Premium Tax Credits.

(Mar. 10, 2004, D.C. Law 15-87, § 4, 50 DCR 10982; Apr. 13, 2005, D.C. Law 15-354, § 49(b), 52 DCR 2638.)

Effect of amendments. — D.C. Law 15-354, in pars. (1) and (2) of subsec. (c), validated previously made technical corrections.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

§ 31-5234. Aggregate limitations on Premium Tax Credits; Premium Tax Credit Allocation Requests.

(a) The aggregate amount of Premium Tax Credits that shall be allowed for all Certified Investors under this chapter shall not exceed \$50 million. No Certified Capital Company, on an aggregate basis with its Affiliates, shall file Premium Tax Credit Allocation Requests in excess of the maximum amount of Premium Tax Credits which may be allowed.

(b) A Premium Tax Credit Allocation Request shall be made by a Certified Investor on a form provided by the Commissioner and filed with the Commissioner by a Certified Capital Company on behalf of the Certified Investor. The

form shall include the affidavit of the Certified Investor pursuant to which the Certified Investor shall irrevocably commit to invest Certified Capital in the Certified Capital Company in the amount of the Premium Tax Credit allocated to it (even if the amount is less than the amount of the Premium Tax Credit Allocation Request). The maximum amount of Premium Tax Credit Allocation Requests which shall be allowed to be filed by any one Certified Investor, on an aggregate basis with its Affiliates, in one or more Certified Capital Companies, shall not exceed the greater of \$10 million or 15% of the aggregate limitation as provided in subsection (a) of this section.

(c) Premium Tax Credits shall be allocated to Certified Investors in Certified Capital Companies in the order that Premium Tax Credit Allocation Requests are filed with the Commissioner by the Certified Capital Companies on their behalf. The Premium Tax Credit Allocation Requests may be filed on or after March 10, 2004, and the filings made before such date shall be considered to have been received by the Commissioner on such date. All filings made on the same day shall be treated as having been made contemporaneously. The deadline for submitting Premium Tax Credit Allocation Requests shall be the first business day which occurs 90 days after the date on which the Commissioner will begin accepting applications for certification as a Certified Capital Company pursuant to § 31-5232.

(d)(1) If 2 or more Certified Capital Companies file Premium Tax Credit Allocation Requests with the Commissioner on behalf of their respective Certified Investors on the same day, and the amount of the Premium Tax Credit Allocation Requests exceeds in the aggregate the limit of available Premium Tax Credits under subsection (a) of this section, Premium Tax Credits shall be allocated among the Certified Investors on a pro rata basis. The pro rata allocation for any one Certified Investor shall be the product of a fraction, the numerator of which is the amount in the Premium Tax Credit Allocation Request filed on behalf of the Certified Investor and the denominator of which is the total of the amounts in all Premium Tax Credit Allocation Requests filed on behalf of all Certified Investors, multiplied by the aggregate limitation as provided in subsection (a) of this section.

(2) No allocation shall be made to the Certified Investors of a Certified Capital Company unless the Certified Capital Company has filed Premium Tax Credit Allocation Requests that are not less than 15% of the Premium Tax Credits available under subsection (a) of this section; provided, that if the allocation process does not result in all Premium Tax Credit Allocation Requests having been filled, the 15% minimum shall be reduced to 10% and then 5% until the aggregate of Premium Tax Credits provided in subsection (a) of this section have been allocated or all Premium Tax Credit Allocation Requests have been filled.

(e) Within 5 business days after the Commissioner receives a Premium Tax Credit Allocation Request filed by a Certified Capital Company, the Commissioner shall notify the Certified Capital Company of the amount of Premium Tax Credits allocated to each of the Certified Investors in the Certified Capital Company.

(f) At the time of receipt of Certified Capital from Certified Investors, the total cash, cash equivalents, or other assets readily available to the Certified

Capital Company to make Certified Investments after deducting the costs and expenses of forming and syndicating the Certified Capital Company shall be an amount equal to or greater than 50% of the total Premium Tax Credit allocated to the Certified Investors under subsection (e) of this section.

(g) If a Certified Capital Company does not receive from a Certified Investor an investment of Certified Capital equaling or exceeding the amount of Premium Tax Credits allocated to the Certified Investor within 5 business days of the Certified Capital Company's receipt of notice of the allocation, the Premium Tax Credits allocated to the Certified Investor shall be forfeited, and the Commissioner, within 5 business days, shall reallocate the Premium Tax Credits among the other Certified Investors in all Certified Capital Companies on a pro rata basis with respect to the Premium Tax Credit Allocation Requests filed.

(Mar. 10, 2004, D.C. Law 15-87, § 5, 50 DCR 10982.)

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

§ 31-5235. Requirements for continuance of certification.

(a) To continue to be certified, a Certified Capital Company shall make Qualified Investments according to the following schedule:

(1) Within the period ending 30 months after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 20% of its Certified Capital;

(2) Within the period ending 4 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 40% of its Certified Capital;

(3) Within the period ending 5 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 50% of its Certified Capital; and

(4) Within the period ending 10 years after its Allocation Date, a Certified Capital Company shall have made Qualified Investments cumulatively equal to 100% of its Certified Capital.

(b)(1) The aggregate cumulative amount of all Qualified Investments made by the Certified Capital Company following its Allocation Date shall be considered in the calculation of the percentage requirements under this chapter. Any proceeds received from a Qualified Investment may be invested in another Qualified Investment and shall count toward any requirement in this chapter with respect to investments of Certified Capital.

(2) For the purposes of satisfying the percentage requirements of subsection (a) of this section only, for each Qualified Investment made after May 27, 2010, a Certified Capital Company that invests in a:

(A) Tier One Qualified Business shall be deemed to have invested \$1.25 for every dollar invested;

(B) Tier Two Qualified Business shall be deemed to have invested \$1.00 for every dollar invested;

(C) Tier Three Qualified Business shall be deemed to have invested \$0.75 for every dollar invested;

(D) Qualified Business that receives an Initial Investment pursuant to a waiver granted in accordance with § 31-5238.03 and that fails to satisfy the eligibility criteria to receive an Initial Investment within 6 months of the date of issuance of the waiver shall be deemed to have invested \$0 for every dollar invested;

(E) Qualified Business that received a Qualified Investment prior to May 27, 2010, and receives a subsequent Qualified Investment after May 27, 2010, shall be deemed to have invested \$1.00 for every dollar invested; and

(F) Qualified Business that receives an Initial Investment or a Follow-on Investment and that fails to maintain satisfaction of the eligibility criteria to receive an Initial or a Follow-on Investment, as applicable, for 6 consecutive months after the date of the Initial or Follow-On Investment shall be deemed to have invested \$0 for every dollar invested.

(c) Notwithstanding any other provision in this chapter, any Qualified Business that has received an Initial Investment may receive a Follow-on Investment if it:

(1) Continues to meet the definition of a Qualified Business other than the requirements set forth in § 31-5231(12)(A)(iv) and (v); and

(2) Certifies in an affidavit that it intends to maintain its headquarters and Principal Business Operations in the District.

(d) No Qualified Investment shall exceed 15% of the total Certified Capital of the Certified Capital Company at the time of investment.

(e) A Certified Capital Company, at least 20 business days prior to making an Initial Investment or Follow-on Investment in a business, shall:

(1) Certify in an affidavit that the business in which it proposes to invest:

(A) In the case of an Initial Investment, is a Qualified Business; or

(B) In the case of a Follow-on Investment, is eligible for a Follow-on Investment pursuant to subsection (c) of this section; and

(2) Submit, along with the certification required by paragraph (1) of this subsection, an explanation of its determination that the business is eligible for an Initial Investment or Follow-on Investment.

(e-1) If, after receiving the affidavit and certification under subsection (e) of this section, the Commissioner determines that a business is not eligible for an Initial Investment or a Follow-on Investment, the Commissioner shall, within 20 days of receiving the affidavit and certification, notify the Certified Capital Company of the determination and provide an explanation.

(f) All Certified Capital not placed in Qualified Investments by the Certified Capital Company may be held or invested in a manner that the Certified Capital Company, in its discretion, considers appropriate; provided, that the Certified Capital Company shall not invest more than 5% of its Certified Capital in any security or policy issued by a Certified Investor or an Affiliate of a Certified Investor or any account maintained by a Certified Investor or Affiliate of any Certified Investor, unless the Certified Investor or an Affiliate thereof is providing a guaranty, indemnity, bond, insurance policy, or other payment undertaking in favor of the Certified Investors, which security or policy is:

(1)(A) Rated “AA” or better by Standard & Poor’s Ratings Group or the equivalent by another nationally-recognized rating agency; or

(B) Issued by, or guaranteed with respect to payment by, an entity whose unsecured indebtedness is rated at least “AA” or its equivalent by a nationally recognized credit rating organization; and

(2) Not subordinated to other unsecured indebtedness of the issuer or the guarantor, as the case may be.

(g) Each Certified Capital Company shall report to the Commissioner as follows:

(1) Within 5 business days after the receipt of Certified Capital, each Certified Capital Company shall report the following to the Commissioner:

(A) The name of each Certified Investor from which the Certified Capital was received, including the Certified Investor’s insurance premium tax identification number;

(B) The amount of each Certified Investor’s investment of Certified Capital and Premium Tax Credits; and

(C) The date on which the Certified Capital was received.

(2) On or before January 31st of each year, each Certified Capital Company shall report the following to the Commissioner:

(A) The amount of the Certified Capital Company’s Certified Capital at the end of the immediately preceding year;

(B) Whether or not the Certified Capital Company has invested more than 15% of its total Certified Capital in any one business; and

(C)(i) All Qualified Investments that the Certified Capital Company made during the previous calendar year, including the number of employees of each Qualified Business in which it has made investments at the time of such investment and as of December 1st of the preceding calendar year; and

(ii) For any Qualified Business in which the Certified Capital Company no longer has an investment, the Certified Capital Company shall provide employment figures for the Qualified Business at the time of such investment and as of the last day before the investment was terminated.

(3) Each Certified Capital Company shall provide to the Commissioner annual audited financial statements, which shall include the opinion of an independent certified public accountant, within 120 days after the end of the fiscal year. In addition, each Certified Capital Company shall provide an agreed-upon procedures report by their independent certified public accountant that shall address the methods of operation and conduct of the business of the Certified Capital Company to determine if the Certified Capital Company is complying with this chapter and the rules and regulations hereunder and that the Certified Capital has been invested as required within the time limits under subsection (a) of this section.

(4) On or before January 31st of each year, each Certified Capital Company shall pay an annual, nonrefundable certification fee of \$10,000 to the Commissioner; provided, that no fee shall be required within 6 months of the initial Allocation Date.

(h) After May 27, 2010, if a Certified Capital Company makes a Qualified Investment in a business that relocates its Principal Business Operations

outside the District prior to the termination of the Qualified Investment or within 6 months after the termination of the Qualified Investment, the cumulative Qualified Investments that the Certified Capital Company will be deemed to have made for the purposes of § 31-5236 will be reduced by the amount of the Qualified Investment in the business that relocated its Principal Business Operations outside the District, unless the business demonstrates that it has returned its Principal Business Operations to the District within 3 months of the relocation.

(Mar. 10, 2004, D.C. Law 15-87, § 6, 50 DCR 10982; Apr. 13, 2005, D.C. Law 15-354, § 49(c), 52 DCR 2638; May 27, 2010, D.C. Law 18-181, § 2(b), 57 DCR 3388.)

Effect of amendments. — D.C. Law 15-354, in par. (3) of subsec. (g), validated previously made technical corrections.

D.C. Law 18-181, in subsec. (a), deleted “; and” from the end of par. (2), substituted “; and” for a period at the end of par. (3), and added par. (4); rewrote subsecs. (b), (c), (e), and (g)(2)(C); and added subsecs. (e-1) and (h).

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

Legislative history of Law 15-354. — For Law 15-354, see notes following § 31-101.

Legislative history of Law 18-181. — For Law 18-181, see notes following § 31-5231.

§ 31-5236. One hundred percent investment requirement.

(a) A Certified Capital Company may make Qualified Distributions at any time. To make a distribution, other than a Qualified Distribution, a Certified Capital Company shall have made Qualified Investments in an amount cumulatively equal to 100% of its Certified Capital. A Certified Capital Company may repay principal and interest on its indebtedness without any restriction, including repayments of indebtedness of the Certified Capital Company on which Certified Investors earned Premium Tax Credits.

(a-1) Notwithstanding any other provision in this chapter, if, pursuant to § 31-5235(a)(4), a Certified Capital Company has not made Qualified Investments cumulatively equal to 100% of its Certified Capital within 10 years after its Allocation Date, the Certified Capital Company shall be prohibited from using its Certified Capital to pay its management fees.

(b)(1) When distributions to holders of equity interests of a Certified Capital Company cumulatively exceed the Certified Capital Company’s original Certified Capital plus any additional capital contributions to the Certified Capital Company (the “Certified Capital Company Capital”), the Certified Capital Company shall report to the Commissioner at the time of the distribution whether the aggregate total of such distributions, when combined with the annual Premium Tax Credits allocated to the Certified Capital Company’s Certified Investors under this chapter to that time, have resulted in an annual internal rate of return exceeding 15% on the Certified Capital Company Capital.

(2) If the Certified Capital Company’s annual internal rate of return, determined in accordance with paragraph (1) of this subsection, exceeds 15%, the Certified Capital Company shall at the time of the distribution pay to the Commissioner an amount equal to 15% of the amount above that required to produce the 15% return.

(Mar. 10, 2004, D.C. Law 15-87, § 7, 50 DCR 10982; May 27, 2010, D.C. Law 18-181, § 2(c), 57 DCR 3388.)

Effect of amendments. — D.C. Law 18-181 added subsec. (a-1).

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

Legislative history of Law 18-181. — For Law 18-181, see notes following § 31-5231.

§ 31-5237. Decertification.

(a) The Commissioner shall conduct an annual review of each Certified Capital Company to determine if the Certified Capital Company is complying with the requirements of certification, to advise the Certified Capital Company as to the eligibility status of its Qualified Investments, and to ensure that no investment has been made in violation of this chapter. The cost of the annual review shall be paid by each Certified Capital Company under a fee schedule adopted by the Commissioner.

(b) Any material violation of this chapter shall be grounds for decertification of the Certified Capital Company. If the Commissioner determines that a Certified Capital Company is not in compliance with the requirements of this chapter, the Commissioner shall, by written notice, inform the officers of the Certified Capital Company that the Certified Capital Company is subject to decertification in 120 days from the date of mailing of the notice unless the deficiencies are corrected.

(c) If the Certified Capital Company is not in compliance with this chapter at the end of the 120-day notice period, the Commissioner may send a notice of decertification to the Certified Capital Company and to all other appropriate District agencies.

(d) Decertification of a Certified Capital Company may cause the recapture of Premium Tax Credits previously claimed and the forfeiture of future Premium Tax Credits to be claimed by Certified Investors with respect to the Certified Capital Company, as follows:

(1) Decertification of a Certified Capital Company within 3 years of the Allocation Date shall cause the recapture of all Premium Tax Credits previously claimed and the forfeiture of all future Premium Tax Credits to be claimed by Certified Investors unless the Certified Capital Company has met the requirements for continued certification as provided in this subsection.

(2) If a Certified Capital Company has met all requirements for continued certification under § 31-5235(a)(1) and subsequently fails to meet the requirements for continued certification under the provisions of § 31-5235(a)(2), the Premium Tax Credits which have been or could be taken, subject to the other provisions of this chapter, by Certified Investors within 3 years from the Allocation Date shall not be subject to recapture or forfeiture; provided, that all other Premium Tax Credits shall be subject to recapture or forfeiture.

(3) If a Certified Capital Company has met all requirements for continued certification under § 31-5235(a)(1) and (2) and is subsequently decertified, the Premium Tax Credits which have been or could be taken, subject to the other provisions of this chapter, by Certified Investors within 4 years from the

Allocation Date shall not be subject to recapture or forfeiture; provided, that all other Premium Tax Credits shall be subject to recapture or forfeiture.

(4) If a Certified Capital Company has met all requirements for continued certification under § 31-5235(a)(1), (2), and (3) and is subsequently decertified, those Premium Tax Credits which have been or could be claimed, subject to the other provisions of this chapter, by Certified Investors within 5 years from the Allocation Date shall not be subject to recapture or forfeiture. The Premium Tax Credits to be claimed subsequent to the 5th anniversary of the Allocation Date shall be subject to forfeiture only if the Certified Capital Company is decertified within 5 years from the Allocation Date.

(5) If a Certified Capital Company has invested an amount cumulatively equal to 100% of its Certified Capital in Qualified Investments, notwithstanding any other provision of this chapter, all Premium Tax Credits shall not be subject to recapture or forfeiture.

(e) If a Certified Capital Company has invested an amount cumulatively equal to 100% of its Certified Capital in Qualified Investments, notwithstanding any other provision of this chapter, the Certified Capital Company shall not be subject to regulation by the Commissioner.

(f) The Commissioner shall send written notice to each Certified Investor whose Premium Tax Credits have been subject to recapture or forfeiture at the address last shown on the last premium tax filing.

(g) Repealed.

(Mar. 10, 2004, D.C. Law 15-87, § 8, 50 DCR 10982; May 27, 2010, D.C. Law 18-181, § 2(d), 57 DCR 3388.)

Effect of amendments. — D.C. Law 18-181, in subsecs. (a) and (b), substituted “this chapter” for “§ 31-5235”; and repealed subsec. (g), which had read as follows: “(g) The Commissioner may waive, pursuant to rules established pursuant to § 31-5239, any recapture or forfeiture of credits if, after considering all facts

and circumstances, he or she determines that the waiver will have the effect of furthering the District’s economic development.”

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

Legislative history of Law 18-181. — For Law 18-181, see notes following § 31-5231.

§ 31-5238. Transferability.

The Premium Tax Credits may be transferred or sold. The Commissioner shall promulgate regulations to facilitate the transfer or sale of Premium Tax Credits. Any the transfer or sale shall not affect the time schedule for claiming the Premium Tax Credits. Any Premium Tax Credits recaptured under § 31-5237 shall be the liability of the Certified Investor that actually claimed the Premium Tax Credits.

(Mar. 10, 2004, D.C. Law 15-87, § 9, 50 DCR 10982.)

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

§ 31-5238.01. Fees deposited in Insurance Regulatory Trust Fund.

All fees collected pursuant to this chapter shall be deposited in the Insurance Regulatory Trust Fund established by § 31-1202 and expended for the purposes authorized by the Fund.

(Mar. 10, 2004, D.C. Law 15-87, § 9a, as added Oct. 20, 2005, D.C. Law 16-33, § 2203, 52 DCR 7503.)

Temporary Addition of Section. — For temporary (225 day) addition, see § 2 of Captive Insurance Company Enhancement Temporary Amendment Act of 2004 (D.C. Law 15-215, December 7, 2004, law notification 52 DCR 459).

Emergency legislation. — For temporary (90 day) addition, see § 2 of the Captive Insurance Company Enhancement Emergency Amendment Act of 2004 (D.C. Act 15-481, July 19, 2004, 51 DCR 7811).

For temporary (90 day) amendment of section, see § 2 of Captive Insurance Company Enhancement Congressional Review Emergency Amendment Act of 2004 (D.C. Act 15-549, October 26, 2004, 51 DCR 10336).

For temporary (90 day) addition, see § 2203 of Fiscal Year 2006 Budget Support Emergency Act of 2005 (D.C. Act 16-168, July 26, 2005, 52 DCR 7667).

Legislative history of Law 16-33. — For Law 16-33, see notes following § 31-1202.

§ 31-5238.02. Compliance and economic impact.

(a) Information, records, or other data received, prepared, used, or retained by the Commissioner pursuant to this subsection shall not be subject to the disclosure requirements of subchapter II of Chapter 5 of Title 2 to the extent that:

(1) The information, records, or other data describe the commercial and financial operations or intellectual property of a business entity or individual;

(2) The information or records have not been publicly disseminated at any time; and

(3) Disclosure of the information or records may put the business entity or individual at a competitive disadvantage.

(b)(1) A Certified Capital Company shall receive and consider applications from every business interested in obtaining funds from the Certified Capital Company. The Certified Capital Company shall maintain a registry of all contacts made with every person or business that contacts the Certified Capital Company for the purpose of obtaining funding. The registry shall be made available to the Commissioner for inspection.

(2) A Certified Capital Company shall provide, at the Commissioner's request, the Commissioner with a detailed written explanation explaining its decision to fund or to decline to fund a prospective business. A Certified Capital Company providing a written explanation pursuant to this paragraph shall include a copy of the prospect's business plan, financial statements, or other documents submitted by the person or business seeking funding. A Certified Capital Company shall also submit to the Commissioner all internal business analysis documents, if any, prepared by the Certified Capital Company that were considered during its decision-making process.

(3) A Certified Capital Company that declines to provide funding to any business shall promptly communicate its decision in writing to the business

seeking the funding. The letter shall include a detailed statement describing the reason the Certified Capital Company declined to fund the business. A copy of the letter shall be sent to the Commissioner.

(c)(1) Each Qualified Business shall once a year provide the Certified Capital Companies from which it has received a Qualified Investment with a report stating the number and type of jobs created and retained in total and in the District, salaries paid to each employee, taxes paid to the District, money spent with local businesses or persons, including landlords, major suppliers and vendors, accountants, auditors, attorneys, and others, and whether such businesses or persons are located in the District or elsewhere.

(2) Each Qualified Businesses shall provide the Certified Capital Company with documents, such as leases, invoices, payroll reports, employment records, tax returns and contracts, in support of the reports required by paragraph (1) of this subsection. The Certified Capital Company shall maintain the reports and supporting documents for a period of not less than 5 years from the date of receipt and shall make this information available to the Commissioner during the annual review.

(d) Notwithstanding any other provision in this chapter, the Commissioner shall promptly make available to the Council and its committees, upon their request, any information made available to or otherwise in the possession of the Commissioner pursuant to this chapter.

(e) The Commissioner shall conduct an Economic Impact Study once a year, beginning with the year ending December 31, 2009, and ending with the year ending December 31, 2014, to determine the economic impact of the Certified Capital Company program on the District's economy. The Certified Capital Companies shall require its Qualified Businesses to provide all information necessary, as determined by the Commissioner or his or her designee, to complete the study. A detailed written report shall be prepared at the conclusion of the study. The Commissioner may retain consultants, economists, and other experts to conduct the Economic Impact Study. The costs of these experts shall be borne by the Certified Capital Companies in proportion to the amount of Certified Capital invested in each Certified Capital Company.

(f) The Commissioner may subject a Certified Capital Company to an administrative penalty not to exceed \$25,000 for any violation of this section, subject to the hearing requirements set forth [in] § 2-509. Prior to imposing a penalty under this section, the Commissioner shall provide the Certified Capital Company with written notice of the violation and at least 30 days to cure the violation.

(Mar. 10, 2004, D.C. Law 15-87, § 9a, as added by May 27, 2010, D.C. Law 18-181, § 2(e), 57 DCR 3388.)

Legislative history of Law 18-181. — For Law 18-181, see notes following § 31-5231.

§ 31-5238.03. Waivers and disqualifications.

The Commissioner may grant a business a 6-month waiver from any of the eligibility criteria to receive an Initial Investment if the Commissioner finds

that the business will meet the eligibility criteria to receive an Initial Investment within 6 months of the date of issuance of the waiver. The waiver shall expire 6 months after it is issued and a business shall not receive an additional waiver pursuant to this section. Upon satisfaction of all eligibility criteria within the 6-month period, the business shall promptly provide the Commissioner with an affidavit stating that the business has satisfied the eligibility criteria to receive an Initial Investment and shall provide any supporting documents requested by the Commissioner.

(Mar. 10, 2004, D.C. Law 15-87, § 9b, as added May 27, 2010, D.C. Law 18-181, § 2(e), 57 DCR 3388.)

Legislative history of Law 18-181. — For Law 18-181, see notes following § 31-5231.

§ 31-5239. Rulemaking.

The Commissioner shall issue rules and regulations to implement this chapter within 120 days of March 10, 2004.

(Mar. 10, 2004, D.C. Law 15-87, § 10, 50 DCR 10982.)

Legislative history of Law 15-87. — For Law 15-87, see notes following § 31-5231.

SUBTITLE IX. INSURANCE ASSOCIATIONS AND SOCIETIES.

CHAPTER 53. FRATERNAL BENEFIT SOCIETIES.

Sec.	Sec.
31-5301. Definitions.	31-5319. Funds.
31-5302. Operation for benefit of members and their beneficiaries; bylaws.	31-5320. Taxation.
31-5303. Qualifications for membership.	31-5321. Applicability of provisions.
31-5304. Location of office.	31-5322. Valuation standards for certificates.
31-5305. Liability of officers and members.	31-5323. Reports.
31-5306. Waiver of laws.	31-5324. Annual license.
31-5307. Organization of societies.	31-5325. Examination of societies; no adverse publications.
31-5308. Laws; amendments.	31-5326. Foreign or alien society; admission.
31-5309. Operations of nonprofit institutions.	31-5327. Injunction; liquidation; receivership of domestic society.
31-5310. Reinsurance.	31-5328. Suspension; revocation or refusal of license of foreign or alien society.
31-5311. Consolidations and mergers.	31-5329. Injunction.
31-5312. Conversion of fraternal benefit society into a mutual life insurance company.	31-5330. Licensing of agents.
31-5313. Benefits.	31-5331. Unfair methods of competition; unfair and deceptive acts and practices.
31-5314. Beneficiaries.	31-5332. Penalties.
31-5315. Benefits not attachable.	31-5333. Exemption of certain societies.
31-5316. Benefit contracts.	31-5334. Review.
31-5317. Nonforfeiture benefits, cash surrender values, certificate loans, and other options.	31-5335. Severability.
31-5318. Investments.	

§ 31-5301. Definitions.

For the purposes of this chapter, the term:

(1) "Benefit contract" means the agreement for provision of benefits authorized by § 31-5313, as that agreement is described in § 31-5316(a).

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(5) "District" means the District of Columbia.

(6) "Fraternal benefit societies" means any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of § 31-5333(a)(2), whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter.

(7) "Laws" means the society's articles of incorporation, charter, constitution and bylaws, however designated.

(8) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

(9) "Lodge System" means a society that has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted

in accordance with its laws, rules, and rituals. Subordinate lodges shall be required by the laws of the society to hold regular meetings periodically in furtherance of the purposes of the society. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership, but membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

(10) "Premiums" means premiums, rates, dues, or other required contributions by whatever name known, which are payable under the certificate.

(11) "Representative form of government" means a society in which:

(A) There is a supreme governing body constituted in one of the following ways:

(i) By assembly if the supreme governing body is composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than a majority of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every 4 years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(ii) By direct election if the supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed 4 years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society;

(B) The officers of the society are elected either by the supreme legislative or governing body or by the board by whatever name known, as provided in the society's constitution and bylaws;

(C) The members, officers, representatives, or delegates shall not vote by proxy; and

(D) Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly.

(12) "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(13) "Society" means fraternal benefit society, unless otherwise indicated.

(Apr. 29, 1998, D.C. Law 12-86, § 1202, 45 DCR 1172; June 11, 2004, D.C. Law 15-166, § 4(ff), 51 DCR 2817.)

Cross references. — Authority of Council to regulate, modify, or eliminate license requirements and to promulgate regulations, see §§ 47-2842 and 47-2844.

Exemption of fraternal benefit associations from provision of general law governing taxes and license fees for insurance companies, see § 47-2611.

Inspection and examination of insurance companies, see §§ 31-208, 31-5201, and 31-5202.

Quo warranto proceedings to question right to corporate rights and franchises, see § 16-3501 et seq.

Prior Codifications. — 1981 Ed., § 35-1231.

Effect of amendments. — D.C. Law 15-166, in par. (4), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance of the District of Columbia”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(ff) of

Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 12-86. — Law 12-86, the “Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-458, which was referred to the Committee on Public Works and the Environment and the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 19, 1997, and January 6, 1998, respectively. Signed by the Mayor on January 21, 1998, it was assigned Act No. 12-256 and transmitted to both Houses of Congress for its review. D.C. Law 12-86 became effective on April 29, 1998.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Short title. — Fraternal Benefit Societies Act of 1998: Section 1201 of D.C. Law 12-86 provided that title XII of the act may be cited as the “Fraternal Benefit Societies Act of 1998.”

§ 31-5302. Operation for benefit of members and their beneficiaries; bylaws.

(a)(1) A society shall operate for the benefit of its members and their beneficiaries by:

(A) Providing benefits as specified in § 31-5313; and

(B) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others.

(2) The purposes of paragraph (2) of this subsection may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to, or amend such laws and rules and shall have other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

(Apr. 29, 1998, D.C. Law 12-86, § 1203, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1232.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

§ 31-5303. Qualifications for membership.

(a) A society shall specify in its laws or rules:

(1) Eligibility standards for each class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age 15 and not greater than age 21;

(2) The process for admission to membership for each membership class; and

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

(Apr. 29, 1998, D.C. Law 12-86, § 1204, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1233. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5304. Location of office.

(a) The principal office of any domestic society shall be located in the District. The meetings of its supreme governing body may be held in any state, district, province, or territory wherein such society has at least one subordinate lodge, or in any other location as determined by the supreme governing body, and all business transacted at the meetings shall be as valid in all respects as if the meetings were held in the District. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b)(1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. The required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that 2 or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June 1st of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, the synopsis may be published in the society's official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members.

(Apr. 29, 1998, D.C. Law 12-86, § 1205, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1234. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5305. Liability of officers and members.

(a) The officers and members of the supreme governing body or any

subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, lawsuit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

(1) In relation to any matter in such action, lawsuit, or proceeding as to which he or she shall finally be adjudged to be, or have been guilty of, breach of a duty as a director, officer, employee or agent of the society; or

(2) In relation to any matter in such action, lawsuit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement.

(c) A society may indemnify or reimburse a person in relation to any matter specified in subsection (b)(1) and (2) of this section if the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of the person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subsection (b)(1) and (2) of this section may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, lawsuit, or proceeding or by a court of competent jurisdiction. The termination of any action, lawsuit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to the person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement.

(d) The right to indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

(e) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(f) No director, officer, employee, member, or volunteer of a society serving without compensation, shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved willful or wanton misconduct.

(Apr. 29, 1998, D.C. Law 12-86, § 1206, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1235. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5306. Waiver of laws.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

(Apr. 29, 1998, D.C. Law 12-86, § 1207, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1236. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5307. Organization of societies.

(a) A domestic society organized on or after April 29, 1998, shall be formed as follows:

(1) Seven or more citizens of the United States, a majority of whom are residents of the District, who desire to form a fraternal benefit society may make, sign, and acknowledge, before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(A) The proposed corporate name of the society, which shall not resemble the name of any society or insurance company already authorized to transact business in the District so as to be misleading or confusing;

(B) The place where its principal office shall be located within the District;

(C) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter; and

(D) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who will manage the affairs and funds of the society for the first year or until the ensuing election, at which all such officers shall be elected by the supreme governing body. The ensuing election shall be held no later than one year from the date of issuance of the permanent certificate of authority.

(2) Duplicate originals of the articles of incorporation, certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications and rates therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commissioner, who may require such further information as the Commissioner deems necessary. The bond with sureties approved by the Commissioner shall be in such amount, not less than \$50,000, nor more than \$500,000, as required by the Commissioner. All documents filed are to be in the English language. If the Commissioner finds that the purposes of the society conform to the requirements of this chapter and all provisions of the law have been

complied with, the Commissioner shall approve the articles of incorporation and issue the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(b) No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commissioner upon cause shown, unless the 100 applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(c) Upon receipt of a preliminary certificate of authority from the Commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(1) Actual bona fide applications for benefits have been secured aggregating at least \$100,000 on not less than 100 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(2) At least 5 subordinate lodges have been established into which the 100 applicants have been admitted;

(3) There has been submitted to the Commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums therefor; and

(4) It shall have been shown to the Commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least 100 applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least \$50,000. Advance premiums shall be held in trust during the period of organization. If the society has not qualified for a certificate of authority within one year, as herein provided, advance premiums shall be returned to applicants.

(d) The Commissioner may make such examination and require such further information as the Commissioner deems necessary. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate of authority to be made and filed with the Recorder of Deeds of the District. A

certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(e) Any incorporated society authorized to transact business in the District at the time this chapter becomes effective shall not be required to reincorporate.

(f) No unincorporated or voluntary association shall be permitted to transact business in the District as a fraternal benefit society.

(Apr. 29, 1998, D.C. Law 12-86, § 1208, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1237. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5308. Laws; amendments.

(a) A domestic society may amend its laws in accordance with the provisions of its laws by action of its supreme governing body at any regular or special meeting or, if its laws so provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within 6 months from the date of submission, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified. Any such amendment shall be filed with the Commissioner.

(b) Within 90 days from the filing of any such amendment, a copy or synopsis thereof shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that the amendments or synopsis, have been furnished to the addressee.

(c) Every foreign or alien society authorized to do business in the District shall file with the Commissioner a duly certified copy of all amendments of, or additions to, its laws within 90 days after enactment.

(d) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

(Apr. 29, 1998, D.C. Law 12-86, § 1209, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1238. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5309. Operations of nonprofit institutions.

A society may create, maintain, and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by § 31-5302(a)(2). Such institutions may furnish services free of charge or at a

reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement.

(Apr. 29, 1998, D.C. Law 12-86, § 1210, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1239. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5310. Reinsurance.

A domestic society may enter into reinsurance transactions only in accordance with Chapter 5 of this title. Notwithstanding that law, a society may reinsure the risks of another society in a consolidation or merger approved by the Commissioner under § 31-5311.

(Apr. 29, 1998, D.C. Law 12-86, § 1211, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1240. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5311. Consolidations and mergers.

A domestic society may enter into agreements of consolidation or merger in accordance with § 31-4443.

(Apr. 29, 1998, D.C. Law 12-86, § 1212, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1241. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5312. Conversion of fraternal benefit society into a mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the applicable requirements of the laws of the District with respect to similar mutual legal reserve life insurance corporations if the plan of conversion has been approved by the Commissioner. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of $\frac{2}{3}$ of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of the plan. No such conversion shall take effect unless approved by the Commissioner who may grant approval if the Commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial.

(Apr. 29, 1998, D.C. Law 12-86, § 1213, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1242. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5313. **Benefits.**

(a) A society may provide the following contractual benefits in any form:

- (1) Death benefits;
- (2) Endowment benefits;
- (3) Annuity benefits;
- (4) Temporary or permanent disability benefits;
- (5) Hospital, medical, or nursing benefits;
- (6) Monument or tombstone benefits to the memory of deceased members;

and

(7) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(Apr. 29, 1998, D.C. Law 12-86, § 1214, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1243. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5314. **Beneficiaries.**

(a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent the portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member. The portion so paid shall not exceed \$2,000.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of the benefit, except to the extent that funeral benefits may be paid as provided in subsection (b) of this section, shall be payable to the estate of the deceased insured in the same manner as other property not exempt. If the owner of the certificate is other than the insured, the proceeds shall be payable to the owner.

(Apr. 29, 1998, D.C. Law 12-86, § 1215, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1244. **Legislative history of Law 12-86.** — For legislative history of D.C. Law 12-86, see His-

torical and Statutory Notes following § 31-5301.

§ 31-5315. Benefits not attachable.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any society, shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

(Apr. 29, 1998, D.C. Law 12-86, § 1216, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1245. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For 5301.

§ 31-5316. Benefit contracts.

(a) Every society authorized to do business in the District shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though the changes, additions, or amendments had been made prior to, and were in force at the time of, the application for insurance. No change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require the owner to pay to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made either: (i) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (ii) in lieu of or in combination with clause (i),

the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in the District unless a copy of the form has been filed with the Commissioner in the manner provided for like policies issued by life, accident, and health insurers in the District. Any certificate issued prior to one year after April 29, 1998 shall conform to the requirements provided by the laws applicable immediately prior to April 29, 1998. Every life, accident and health or disability insurance certificate and every annuity certificate issued on or after one year from April 29, 1998 shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life, accident, and health insurers in the District, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that a member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of the certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to the transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

(Apr. 29, 1998, D.C. Law 12-86, § 1217, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1246.

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For

5301.

§ 31-5317. Nonforfeiture benefits, cash surrender values, certificate loans, and other options.

(a) For certificates issued prior to one year after April 29, 1998, the value of

every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to April 29, 1998.

(b) For certificates issued on or after one year from April 29, 1998 for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of the District applicable to life insurers issuing policies containing like benefits based upon such tables.

(Apr. 29, 1998, D.C. Law 12-86, § 1218, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1247. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For 5301.

§ 31-5318. Investments.

A domestic society shall invest its funds only in investments authorized by the laws of the District for the investment of assets of life insurers and subject to the limitations therein. Any foreign or alien society permitted or seeking to do business in the District which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

(Apr. 29, 1998, D.C. Law 12-86, § 1219, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1248. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For 5301.

§ 31-5319. Funds.

(a) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special

procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis which § 31-5316(b) and (d) shall not apply.

(Apr. 29, 1998, D.C. Law 12-86, § 1220, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35- legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-1249.

Legislative history of Law 12-86. — For 5301.

§ 31-5320. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

(Apr. 29, 1998, D.C. Law 12-86, § 1221, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35- legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-1250.

Legislative history of Law 12-86. — For 5301.

§ 31-5321. Applicability of provisions.

Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of the District unless they are expressly designated therein, or unless they are specifically made applicable by this chapter.

(Apr. 29, 1998, D.C. Law 12-86, § 1222, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35- legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-1251.

Legislative history of Law 12-86. — For 5301.

§ 31-5322. Valuation standards for certificates.

(a) Standards of valuation for certificates issued prior to one year after April 29, 1998 shall be those provided by the laws applicable immediately prior to April 29, 1998.

(b)(1) The minimum standards of valuation for certificates issued on or after one year from April 29, 1998 shall be based on the following tables:

(A) For certificates of life insurance, the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers in the District; and

(B) For annuity and pure endowment certificates, for total and perma-

nent disability benefits, for accidental death benefits, and for noncancelable accident and health benefits, such tables as are authorized for use by life insurers in the District.

(2) The valuation methods and standards (including interest assumptions) set forth in paragraph (1) of this subsection shall be in accordance with the laws of the District applicable to life insurers issuing policies containing like benefits.

(c) The Commissioner may, in his or her discretion, accept other standards for valuation if the Commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The Commissioner may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in the District.

(d) Any society, with the consent of the Commissioner of the state of domicile of the society and under such conditions, if any, which the Commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

(Apr. 29, 1998, D.C. Law 12-86, § 1223, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1252. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For 5301.

§ 31-5323. Reports.

(a) Every society transacting business in the District shall annually, on or before March 1, unless for cause shown the time has been extended by the Commissioner, file with the Commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a filing fee of \$50. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the Commissioner.

(b) As part of the annual statement, each society shall, on or before March 1, file with the Commissioner a valuation of its certificates in force on the preceding December 31. The Commissioner may, in his or her discretion for cause shown, extend the time for filing the valuation for not more than 2 calendar months. The valuation shall be done in accordance with the standards specified in § 31-5322. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(c) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit \$100 for each day during which the neglect continues, and, upon notice by the Commissioner to that effect, its authority to do business in the District shall cease while the default continues.

(Apr. 29, 1998, D.C. Law 12-86, § 1224, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1253. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.
Legislative history of Law 12-86. — For

§ 31-5324. Annual license.

Societies which are now authorized to transact business in the District, and all societies hereafter licensed, may continue such business until March 1 next succeeding April 29, 1998. The authority of the societies and all societies hereafter licensed, may thereafter be renewed annually, but in all cases to terminate on the succeeding March 1. However, a license so issued shall continue in full force and effect until a renewal of the license has been specifically refused. For each such license or renewal the society shall pay the Commissioner a fee of \$50. A duly certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

(Apr. 29, 1998, D.C. Law 12-86, § 1225, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1254. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.
Legislative history of Law 12-86. — For

§ 31-5325. Examination of societies; no adverse publications.

(a) The Commissioner, or any person he or she may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in the District in the same manner as authorized for examination of domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

(Apr. 29, 1998, D.C. Law 12-86, § 1226, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1255. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.
Legislative history of Law 12-86. — For

§ 31-5326. Foreign or alien society; admission.

No foreign or alien society shall transact business in the District without a certificate of authority issued by the Commissioner in accordance with §§ 31-4501 and 31-4502 and § 31-2502.21.

(Apr. 29, 1998, D.C. Law 12-86, § 1227, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1256. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5327. Injunction; liquidation; receivership of domestic society.

(a) When the Commissioner, upon investigation, finds that a domestic society has exceeded its powers; has failed to comply with any provision of this chapter; is not fulfilling its contracts in good faith; has a membership of less than 90 after an existence of one year or more; or is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business, the Commissioner shall notify the society of such deficiency and state in writing the reasons for his or her dissatisfaction. The Commissioner shall immediately issue a written notice to the society requiring that the deficiency be corrected. After such notice the society shall have a 30-day period in which to comply with the Commissioner's request for correction. If the society fails to comply, the Commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the Commissioner may present the facts relating thereto to the Corporation Counsel of the District who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until the:

(1) Commissioner finds that the violation complained of has been corrected;

(2) Costs of such action shall have been paid by the society if the court finds that the society was in default as charged;

(3) Court has dissolved its injunction; and

(4) Commissioner has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed immediately to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(e) No action under this section shall be recognized in any court of the District unless brought by the Corporation Counsel upon request of the Commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the Commissioner as such receiver.

(f) The provisions of this section relating to hearing by the Commissioner, action by the Corporation Counsel at the request of the Commissioner, hearing by the court, injunction and receivership shall be applicable to a society which voluntarily determines to discontinue business.

(Apr. 29, 1998, D.C. Law 12-86, § 1228, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1257. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

§ 31-5328. Suspension; revocation or refusal of license of foreign or alien society.

(a) When the Commissioner, upon investigation, finds that a foreign or alien society transacting or applying to transact business in the District has exceeded its powers; has failed to comply with any of the provisions of this chapter; is not fulfilling its contracts in good faith; or is conducting its business fraudulently or in a manner hazardous to its members, creditors, or the public, the Commissioner shall notify the society of the deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The Commissioner shall immediately issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After the notice, the society shall have a 30-day period in which to comply with the Commissioner's request for correction. If the society fails to comply, the Commissioner shall notify the society of the findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked, or refused.

(b) If on such date the society does not present good and sufficient reason why its authority to do business in the District should not be suspended, revoked, or refused, the Commissioner may suspend or refuse the license of the society to do business in the District until satisfactory evidence is furnished to the Commissioner that such suspension or refusal should be withdrawn or the Commissioner may revoke the authority of the society to do business in the District.

(c) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in the District during the time such society was legally authorized to transact business herein.

(Apr. 29, 1998, D.C. Law 12-86, § 1229, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1258. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

§ 31-5329. Injunction.

No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of the District unless made by the Corporation Counsel upon request of the Commissioner.

(Apr. 29, 1998, D.C. Law 12-86, § 1230, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1259. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5330. Licensing of agents.

(a) Agents of societies shall be licensed in accordance with the provisions of the laws regulating the licensing, revocation, suspension, or termination of license of resident and nonresident agents. No written or other examination shall be required of a person who is certified by a society as having been its full-time agent prior to April 29, 1998.

(b) No examination or license shall be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent, representative, or member of a society who devotes, or intends to devote, less than 50% of such person's time to the solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a) of this section. Any person who, in the preceding calendar year, has received or will receive a commission or other compensation for soliciting and procuring the type of contracts listed in paragraphs (1) through (5) of this subsection on behalf of an individual society, shall be presumed to be devoting, or intending to devote, 50% of the person's time to the solicitation or procurement of insurance contracts for such society:

(1) Life insurance contracts that, in the aggregate, exceed \$200,000 of coverage for all lives insured for the preceding calendar year;

(2) A permanent life insurance contract offering more than \$10,000 of coverage on an individual life;

(3) A term life insurance contract offering more than \$50,000 of coverage on an individual life;

(4) Any insurance contracts other than life that the fraternal benefit society may write that insure the individual lives of more than 23 individuals; or

(5) Any variable life insurance or variable annuity contract.

(Apr. 29, 1998, D.C. Law 12-86, § 1231, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1260. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5331. Unfair methods of competition; unfair and deceptive acts and practices.

Every society authorized to do business in the District and its agents shall be subject to the provisions of law applicable to life, accident, and health insurers

relating to unfair and deceptive practices; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

(Apr. 29, 1998, D.C. Law 12-86, § 1232, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1261. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5332. Penalties.

(a) Any person who makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from a benefit in any society shall, upon conviction, be fined not less than \$100 nor more than \$5,000 or be subject to imprisonment not less than 30 days nor more than one year, or both.

(b) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in the District shall, upon conviction thereof, be punished by a fine of not less than \$50 nor more than \$200, or by imprisonment for not less than 30 days nor more than one year, or both, in the discretion of the court.

(c) Any person convicted of a willful violation of, or neglect or refusal to comply with, any provision of this chapter for which a penalty is not otherwise prescribed shall, upon conviction, be punished by a fine not exceeding \$5,000.

(d) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties prescribed by law.

(Apr. 29, 1998, D.C. Law 12-86, § 1233, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1262. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

Legislative history of Law 12-86. — For

§ 31-5333. Exemption of certain societies.

(a) Nothing contained in this chapter shall be construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders, or associations now doing business in the District which provide benefits exclusively through local or subordinate lodges;

(2) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their

families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(3) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than \$700 or disability benefits of not more than \$650 to any person in any one year, or both;

(4) Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than \$400 or for disability benefits of not more than \$350 to any one person in any one year, or both; or

(5) Grand or subordinate lodges of the Independent Order of Odd Fellows, nor any grand or subordinate lodge, or other body of Free and Accepted Masons, the National Council or any subordinate council of the Junior Order United American Mechanics, the National Council or any subordinate council of the Daughters of America, the Supreme Council of the Knights of Columbus or any subordinate council thereof, or similar orders, associations, or societies that do not have as their principal object the issuance of benefit certificates of membership in case of death or the payment of sick, funeral, or death benefits exceeding in amount \$100.

(b) Any such society or association described in subsection (a)(3) or (4) of this section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subsection (a)(4) of this section which has more than 1000 members, shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof.

(c) No society which is exempt from the requirements of this chapter, except any society described in subsection (a)(2) of this section, shall give or allow, or promise to give or allow, to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to such society.

(e) The Commissioner may require from any society or association, by examination or otherwise, such information as will enable the Commissioner to determine whether the society or association is exempt from the provisions of this chapter.

(f) Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of the District.

(Apr. 29, 1998, D.C. Law 12-86, § 1234, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1263.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5301.

§ 31-5334. **Review.**

All decisions and findings of the Commissioner made under the provisions of this chapter shall be subject to review as provided by subchapters I and II of Chapter 2 of Title 5.

(Apr. 29, 1998, D.C. Law 12-86, § 1235, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1264. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For 5301.

§ 31-5335. **Severability.**

If any provision of this chapter or the application of such provision to any circumstance is held invalid, the remainder of this chapter or the application of the provision to other circumstances, shall not be affected thereby.

(Apr. 29, 1998, D.C. Law 12-86, § 1236, 45 DCR 1172.)

Prior Codifications. — 1981 Ed., § 35-1265. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-

Legislative history of Law 12-86. — For 5301.

CHAPTER 54. LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

Sec.	Sec.
31-5401. Definitions.	31-5411. Miscellaneous.
31-5402. Coverage and limitations.	31-5412. Examination of the Association; annual report.
31-5403. Creation of the Association.	31-5413. Tax exemptions.
31-5404. Board of Directors.	31-5414. Immunity.
31-5405. Powers and duties of the Association.	31-5415. Stay of proceedings; reopening default judgments.
31-5406. Assessments.	31-5416. Prohibited advertisement of Association act in insurance sale; notice to policyholders.
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31-5410. Credits for assessments paid.	

§ 31-5401. Definitions.

For the purposes of this chapter, the term:

- (1) "Account" means either of the 2 accounts created under § 31-5403.
- (2) "Association" means the District of Columbia Life and Health Insurance Guaranty Association created under § 31-5403.
- (3) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under § 31-5402.
- (4) "Covered policy" means any policy, contract or group certificate within the scope of § 31-5402.
- (5) "Impaired insurer" means a member insurer which, after July 22, 1992, is not an insolvent insurer, and (A) is deemed by the Mayor to be potentially unable to fulfill its contractual obligations, or (B) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- (6) "Insolvent insurer" means a member insurer which, after July 22, 1992, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
- (7) "Mayor" means the Mayor of the District of Columbia or the Mayor's designee.
- (8) "Member insurer" means any insurer licensed or holding a certificate of authority in the District of Columbia to sell any kind of insurance for which coverage is provided under § 31-5402. The term "member insurer" shall include Group Hospitalization and Medical Services, Inc., as well as any insurer whose license or certificate of authority in the District of Columbia may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:
 - (A) A nonprofit hospital or medical service organization;
 - (B) A health maintenance organization;
 - (C) A fraternal benefit society;
 - (D) A mandatory state pooling plan;
 - (E) A mutual assessment company or any entity that operates on an assessment basis;
 - (F) A risk retention group;
 - (G) An insurance exchange; or
 - (H) Any entity similar to any of the above.

(9) “Moody’s Corporate Bond Yield Average” means the Monthly Average Corporates as published by Moody’s Investors Services, Inc., or any successor thereto.

(10) “Person” means any individual, corporation, partnership, association, or voluntary organization.

(11) “Premiums” means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned, and less dividends and experience credits. The term “premiums” does not include any amounts received for policies or contracts for which coverage is not provided under § 31-5402(b), except that assessable premiums shall not be reduced on account of § 31-5402(b)(2)(C) relating to interest limitations, and § 31-5402(c)(2) relating to limitations with respect to any 1 individual, any 1 participant, and any 1 contract holder.

(12) “Resident” means any person who resides in the District of Columbia at the time a member insurer is determined to be impaired or insolvent and to whom the member insurer owes a contractual obligation. A person may reside in only 1 state, which, in the case of a person other than a natural person, shall be its domiciliary jurisdiction.

(13) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(14) “Supplemental contract” means any agreement entered into for the distribution of policy or proceeds.

(July 22, 1992, D.C. Law 9-129, § 2, 39 DCR 4036; May 21, 1997, D.C. Law 11-268, § 10(u), 44 DCR 1730; June 11, 2004, D.C. Law 15-166, § 4(gg), 51 DCR 2817.)

Prior Codifications. — 1981 Ed., § 35-1941.

Effect of amendments. — D.C. Law 15-166, in par. (13), substituted “Commissioner of the Department of Insurance, Securities, and Banking” for “Commissioner of Insurance and Securities”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(gg) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 9-129. — Law 9-129, the “Life and Health Insurance Guaranty Association Act of 1992,” was introduced in Council and assigned Bill No. 9-186, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on April 7, 1992, and May 6, 1992, respectively. Signed by the Mayor on May 28, 1992, it was assigned Act No. 9-214 and transmitted to both Houses of Congress for

its review. D.C. Law 9-129 became effective on July 22, 1992.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

Delegation of Authority. — Delegation of authority under D.C. Law 9-129, the Life and Health Insurance Guaranty Association Act of 1992, see Mayor’s Order 92-120, October 13, 1992.

§ 31-5402. Coverage and limitations.

(a) Coverage shall be provided for the policies and contracts issued to:

(1) Persons who, regardless of where they reside (except for nonresident

certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under paragraph (2) of this subsection; and

(2) Persons who are owners of, or certificate holders under, such policies or contracts, and who:

(A) Are residents; or

(B) Are not residents, subject to the following conditions:

(i) The insurers which issued and delivered the policies or contracts are domiciled in the District of Columbia;

(ii) The insurers never held a license or certificate of authority in the states in which the persons reside; and

(iii) The states have associations similar to the Association created by this chapter and are not eligible for coverage by the associations.

(b)(1) Coverage shall be provided to the persons specified in subsection (a) of this section for direct, non-group life, health, annuity, and supplemental policies or contracts, and for certificates under direct group policies or contracts, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(2) Coverage shall not be provided for:

(A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the holder of the policy, contract, or certificate;

(B) Any policy or contract of reinsurance, unless assumption certificates have been issued and delivered;

(C) Any portion of a policy, contract, or certificate if the rate of interest on which it is based:

(i) Averaged over the 4-year period prior to the date on which the Association becomes obligated with respect to the policy, contract, or certificate, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for that same 4-year period or for a lesser period if the policy, contract, or certificate was issued and delivered less than 4 years before the Association became obligated; and

(ii) On and after the date on which the Association becomes obligated with respect to the policy, contract, or certificate, exceeds the rate of interest determined by subtracting 3 percentage points from the most recent Moody's Corporate Bond Yield Average;

(D) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity under:

(i) A Multiple Employer Welfare Arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144), as amended;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(E) Any portion of a policy, contract, or certificate to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy, contract, or certificate holder, in connection with the service to or administration of the policy, contract, or certificate;

(F) Any policy, contract, or certificate issued and delivered in the District of Columbia by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue and deliver the policy, contract, or certificates in the District of Columbia; or

(G) Any unallocated annuity contract.

(c) The benefits for which the Association may become liable shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2)(A) With respect to any 1 life, regardless of the number of policies, contracts, or certificates:

(i) \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;

(ii) \$100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; or

(iii) \$300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) The liability of the Association shall be limited strictly by the express terms of the policies or contracts and by this chapter, and shall not be affected by the contents of any brochures, illustrations, advertisements in print or electronic media, or other advertising material used in connection with the sale of the policies or contracts, or by oral statements made by agents or other sales representatives in connection with the sale of the policies or contracts. The Association shall not be liable for extra-contractual damages, punitive damages, attorney fees, or interest other than as provided for by the terms of the policies or contracts as limited by this chapter, that might be awarded by any court or governmental agency in connection with the policies or contracts.

(d) In no event shall the Association be liable to expend more than \$300,000 in the aggregate with respect to any 1 individual.

(July 22, 1992, D.C. Law 9-129, § 3, 39 DCR 4036.)

Section references. — This section is referred to in §§ 31-5401, 31-5405, and 31-5416.

Prior Codifications. — 1981 Ed., § 35-1942.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5403. Creation of the Association.

(a)(1) There is created a nonprofit legal entity to be known as the District of Columbia Life and Health Insurance Guaranty Association.

(2) All member insurers shall be and shall continually remain members of the Association as a condition of their authority to transact insurance business in the District of Columbia.

(3) The Association shall perform its functions under the plan of operation established and approved under § 31-5407 and shall exercise its powers through a board of directors established under § 31-5404.

(4) For purposes of administration and assessment the Association shall maintain 2 accounts:

(A) The life insurance and annuity account which shall include the following subaccounts:

(i) Life insurance account; and

(ii) Annuity account; and

(B) The health insurance account.

(b) The Association shall come under the immediate supervision of the Mayor and shall be subject to the applicable provisions of the insurance laws of the District of Columbia.

(July 22, 1992, D.C. Law 9-129, § 4, 39 DCR 4036.)

Section references. — This section is referred to in § 31-5401.

Prior Codifications. — 1981 Ed., § 35-1943.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5404. Board of Directors.

(a)(1) The Board of Directors of the Association (“Board” or “Board of Directors”) shall consist of no less than 5 and no more than 9 member insurers serving terms as established in the plan of operation.

(2) The members of the Board shall be selected by member insurers subject to the approval of the Mayor.

(3) Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members, subject to the approval of the Mayor.

(b) The Mayor shall give notice to all member insurers of the time and place of the organizational meeting to select the initial Board of Directors, and to initially organize the Association.

(c) In determining voting rights at the organizational meeting, each member insurer shall be entitled to 1 vote in person or by proxy.

(d) If the Board of Directors is not selected within 60 days after notice of the organizational meeting, the Mayor may appoint the initial members.

(e) In approving selections or in appointing members to the Board, the Mayor shall consider, among other things, whether all member insurers are fairly represented.

(f) Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors, but shall not otherwise be compensated by the Association for their services.

(July 22, 1992, D.C. Law 9-129, § 5, 39 DCR 4036.)

Section references. — This section is referred to in §§ 31-5403, and 31-5407.

Prior Codifications. — 1981 Ed., § 35-1944.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5405. Powers and duties of the Association.

(a) If a member insurer is an impaired domestic insurer, the Association may, in its discretion and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer that are approved by the Mayor, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies, contracts, or certificates of the impaired insurer;

(2) Provide monies, pledges, notes, guarantees, or other proper means to effectuate paragraph (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (1) of this subsection; or

(3) Loan money to the impaired insurer.

(b)(1) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in paragraph (2) of this subsection, the Association shall, in its discretion, either:

(A) Take any of the actions specified in subsection (a) of this section, subject to the conditions therein; or

(B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for them under claims of emergency or hardship in accordance with standards proposed by the Association and approved by the Mayor.

(2) The Association shall be subject to the requirements of paragraph (1) of this subsection only:

(A) If the laws of the member insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligation by all guaranty associations, along with all expenses and interest on all payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(i) The delinquency proceeding shall not be dismissed;

(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and

(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(B) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in the District of Columbia; or

(C) If the impaired insurer is a foreign or alien insurer:

(i) It has been prohibited from soliciting or accepting new business in the District of Columbia;

(ii) Its certificate of authority has been suspended or revoked in the District of Columbia; and

(iii) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of insurance of the state.

(c) If a member insurer is an insolvent insurer, the Association shall, in its discretion:

(1)(A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies, contracts, and certificates of the insolvent insurer;

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide the monies, pledges, guarantees, or other means as are reasonably necessary to discharge the duties; or

(2) With respect only to life and health insurance policies and certificates, provide benefits and coverages in accordance with subsection (d) of this section.

(d) When proceeding under subsection (b)(1)(B) or (c)(2) of this section, the Association shall, with respect only to life and health insurance policies and certificates:

(1) Assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer for claims insured. The payment of benefits required by this paragraph shall be made:

(A) With respect to group policies, not later than the earlier of the next renewal date under the policies or 45 days, but in no event less than 30 days after the date on which the Association becomes obligated with respect to the policies; or

(B) With respect to individual policies, not later than the earlier of the next renewal date, if any, under the policies or 1 year, but in no event less than 30 days from the date on which the Association becomes obligated with respect to the policies;

(2) Make diligent efforts to provide all known insureds group policy and certificate holders with respect to group policies 30-days notice of the termination of the benefits provided; and

(3) Make available, with respect to individual policies, to each known insured, or owner if other than the insured; with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (e) of this section, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(e)(1) In providing the substitute coverage required under subsection (d)(3) of this section, the Association may offer to reissue the terminated coverage or to issue an alternative policy.

(2) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policies.

(3) The Association may reinsure any alternative or reissued policy.

(f)(1) Alternative policies adopted by the Association shall be subject to the approval of the Mayor. The Association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(2) Alternative policies shall contain at least the minimum statutory provisions required in the District of Columbia and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(3) Alternative policies issued and delivered by the Association shall provide coverage of a type similar to that of the policies issued and delivered by the impaired or insolvent insurer, as determined by the Association.

(g) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to prior approval of the Mayor or by a court of competent jurisdiction.

(h) The Association's obligations with respect to coverage under policies of the impaired or insolvent insurer or under any reissued or alternative policies shall cease on the date the policies are replaced by other similar policies by either the policyholder, the insured, or the Association.

(i) When proceeding under subsection (b)(1)(B) or (c) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with § 31-5402(b)(2)(C).

(j) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(k) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(l) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of the District of Columbia by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer, other than the District of Columbia.

(m) In carrying out its duties under subsections (b) and (c) of this section, the Association may, subject to approval by the court:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts which can be assessed under this chapter are less than the amount needed to assure full and prompt performance of the Association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of a permanent policy or contract lien, to be in the public interest; or

(2) Impose temporary moratoriums on liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

(n) If the Association fails to act within a reasonable period of time under subsections (b)(1)(B), (c), and (d) of this section, the Mayor shall assume the powers and duties of the Association under this chapter with respect to impaired or insolvent insurers.

(o) The Association may render assistance and advice to the Mayor, upon request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(p) The Association shall have standing to appear before any court in the District of Columbia with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated under this chapter. Standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear before a court in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or a court with jurisdiction over a 3rd party against whom the Association may have rights through subrogation of the insurer's policyholders.

(q)(1) Any person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the Association, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The Association may require an assignment to it of the rights and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon such a person.

(2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(3) In addition to paragraphs (1) and (2) of this subsection, the Association shall have all common law rights of subrogation and any other equitable or

legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contracts.

(r) The Association may:

(1) Enter into contracts necessary or proper to carry out the provisions and purposes of this chapter;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 31-5406 and to settle claims or potential claims against it;

(3) Borrow money to carry out the purposes of this chapter; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain persons necessary to handle the financial transactions of the Association, and to perform other functions necessary or proper under this chapter;

(5) Take legal action necessary to avoid payment of improper claims; and

(6) Exercise, for the purposes of this chapter and to the extent approved by the Mayor, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter.

(s) The Association may join an organization of 1 or more other state associations of similar purposes to further the purposes and administration of the powers and duties of the Association.

(July 22, 1992, D.C. Law 9-129, § 6, 39 DCR 4036; Mar. 24, 1998, D.C. Law 12-81, § 31(a), 45 DCR 745.)

Section references. — This section is referred to in §§ 31-5406, 31-5407, and 31-5411.

Prior Codifications. — 1981 Ed., § 35-1945.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 12-81. — Law 12-81, the “Technical Amendments Act of 1998,” was introduced in Council and assigned Bill No. 12-408, which was referred to the Commit-

tee of the Whole. The Bill was adopted on first and second readings on November 4, 1997, and December 4, 1997, respectively. Signed by the Mayor on December 22, 1997, it was assigned Act No. 12-246 and transmitted to both Houses of Congress for its review. D.C. Law 12-81 became effective on March 24, 1998.

Editor’s notes. — “Subsection (e) of this section”, referred to in (d)(3), was substituted for the language “paragraph (4) of this subsection” which appeared in § 6 of D.C. Law 9-129.

§ 31-5406. Assessments.

(a) The Board of Directors shall assess the member insurers for the amounts necessary to carry out the powers and duties of the Association. Assessments shall be made separately for the life insurance and annuity account and for the health insurance account and shall be maintained in a District of Columbia bank, which is subject to the District of Columbia Community Development Program under the supervision of the District of Columbia Office of Banking and Financial Institutions. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest monthly until paid.

(b) There shall be 2 assessments, as follows:

(1) Class A assessments shall be made for the purposes of meeting

administrative and legal costs and other expenses and examinations conducted under the authority of § 31-5409(e). Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under § 31-5405 with regard to an impaired or insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the Board and may be made on a pro rata or non-pro rata basis. If pro rata, the Board may provide that it be credited against future Class B assessments. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the Board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account and subaccount shall be in the same proportion as the premiums received on business in the District of Columbia by each assessed member insurer on policies and contracts covered by each account for the 3 most recent calendar years, for which information is available, preceding the year in which the insurer became impaired or insolvent bears to the premiums received on business in the District of Columbia for these calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d)(1) The Association may abate or defer, in whole or in part, the assessment of a member insurer if the Board concludes that payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations.

(2) In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e)(1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any 1 calendar year exceed 2% and for the health account shall not in any 1 calendar year exceed 2% of the insurer's average premiums received in the District of Columbia on the policies and contracts covered by the account during the 3 calendar years preceding the year in which the insurer is declared impaired or insolvent. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any 1 year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(2) The Board may provide in the plan of operation a method of allocating funds among claims, whether relating to 1 or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If a 1% assessment for any subaccount of the life and annuity account in any 1 year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subsection (c)(2) of this section, the Board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (1) of this subsection.

(f)(1) The Board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out, during the coming year, the obligations of the Association with regard to that account, including assets accruing from assignments, subrogation, net realized gains, and income from investments.

(2) A reasonable amount may be retained in any account in a District of Columbia bank, which is subject to the District of Columbia Community Development Program under the supervision of the District of Columbia Office of Banking and Financial Institutions, to provide funds for the continuing expenses of the Association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policyholder dividends for any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The Association shall issue to each insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Mayor, for the amount of the assessment so paid. All outstanding certificates shall be of equal value, dignity, and priority without references to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the Mayor may approve.

(July 22, 1992, D.C. Law 9-129, § 7, 39 DCR 4036.)

Cross references. — Premium tax liability offsets, see § 31-205.

Section references. — This section is referred to in §§ 31-5405, 31-5407, and 31-5410.

Prior Codifications. — 1981 Ed., § 35-1946.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5407. Plan of operation.

(a)(1) The Association shall submit to the Mayor a plan of operation, and any subsequent amendments that are necessary or suitable, to assure the fair, reasonable, and equitable administration of the Association. The plan of operation, and any amendments, shall become effective 30 days following its

submission to the Mayor, unless the Mayor has issued written disapproval of the plan within the 30 days.

(2) If the Association fails to submit a suitable plan of operation within 120 days following July 22, 1992, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Mayor shall, after notice and hearing, adopt and promulgate reasonable rules as necessary or advisable to carry out the provisions of this chapter. These rules shall continue in force until modified by the Mayor or superseded by a plan submitted by the Association and approved by the Mayor.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation, in addition to requirements enumerated elsewhere in this chapter, shall:

(1) Establish procedures for handling the assets of the Association;

(2) Establish the amount and method of reimbursement of members of the Board of Directors under § 31-5404;

(3) Establish regular places and times for meetings, including telephone conference calls, of the Board of Directors;

(4) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board of Directors;

(5) Establish the procedures whereby nominations to the Board of Directors will be made and submitted to the Mayor for approval;

(6) Establish any additional procedures necessary for assessments under § 31-5406; and

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

(d)(1) The plan of operation may provide that any or all powers and duties of the Association, except those under § 31-5405(q)(3) and § 31-5406, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this Association, or its equivalent in 2 or more states.

(2) Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association.

(3) A delegation under this subsection shall take effect only with the approval of the Board of Directors and the Mayor, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

(July 22, 1992, D.C. Law 9-129, § 8, 39 DCR 4036.)

Section references. — This section is referred to in § 31-5403.

Prior Codifications. — 1981 Ed., § 35-1947.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5408. Duties and powers of the Mayor.

In addition to the duties and powers enumerated elsewhere in this chapter, the Mayor shall:

(1) Upon request of the Board of Directors, provide the Association with a statement of the premiums in the District of Columbia and any other appropriate states for each member insurer; and

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer to comply promptly with such a demand shall not excuse the Association from the performance of its powers and duties under this chapter.

(July 22, 1992, D.C. Law 9-129, § 9, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1948. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5409. Prevention of insolvencies.

(a) To aid in the detection and prevention of insurer impairments or insolvencies, the Mayor shall:

(1) Transmit written notices to the insurance commissioners of all the other states and territories of the United States, within 30 days following the date any action is taken, when the Mayor takes any of the following actions against a member insurer:

(A) Revocation of license;

(B) Suspension of license; or

(C) Issuance of any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the District of Columbia, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors;

(2) Report to the Board of Directors when the Mayor has taken any of the actions set forth in paragraph (1) of this subsection or has received a report from any insurance commissioner indicating that any similar action has been taken in another state. The report shall contain all significant details of the action taken, or shall include the report received from another insurance commissioner;

(3) Report to the Board of Directors when the Mayor has reasonable cause to believe, from any examination, whether completed or in process, of any member company, that the company may be an impaired or insolvent insurer; and

(4) Furnish to the Board of Directors the ratios developed by the National Association of Insurance Commissioners' Insurance Regulatory Information System, and listings of companies not included in the ratios. The Board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information shall be kept confidential by the Board of Directors until it is made public by the Mayor or other lawful authority.

(b) The Mayor may seek the advice and recommendations of the Board of Directors concerning any matter affecting the Mayor's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in the District of Columbia.

(c) The Board of Directors may, upon majority vote, make reports and recommendations to the Mayor upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer, or germane to the solvency of any company seeking to transact insurance business in the District of Columbia. These reports and recommendations shall be internal working documents, and, consequently, shall not be considered public documents.

(d) It shall be the duty of the Board of Directors, upon majority vote, to notify the Mayor of any information indicating whether any member insurer may be an impaired or insolvent insurer.

(e)(1) The Board of Directors may, upon majority vote, request that the Mayor order an examination of any member insurer which the Board, in good faith, believes may be an impaired or insolvent insurer.

(2) Within 30 days of receipt of such a request, the Mayor shall begin the examination.

(3) The examination may be conducted as a National Association of Insurance Commissioners examination, or may be conducted by persons designated by the Mayor.

(4) The cost of the examination shall be paid by the Association and the examination report shall be treated the same as other examination reports.

(5) In no event shall the examination report be released to the Board of Directors prior to its release to the public, except in compliance with subsection (a) of this section.

(6) The Mayor shall notify the Board of Directors when the examination is completed.

(7) The request for an examination shall be kept on file by the Mayor, but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The Board of Directors may, upon majority vote, make recommendations to the Mayor for the detection and prevention of insurer insolvencies.

(g) The Board of Directors, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, shall:

(1) Prepare and submit a written report to the Mayor containing all information it possesses bearing on the history and causes of the insolvency; and

(2) Cooperate with the boards of directors of guaranty associations in other states in preparing reports on the history and causes of insolvency of a particular insurer. The Association may adopt by reference any report prepared by other associations.

(July 22, 1992, D.C. Law 9-129, § 10, 39 DCR 4036.)

Section references. — This section is referred to in § 31-5406.

Prior Codifications. — 1981 Ed., § 35-1949.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

§ 31-5410. Credits for assessments paid.

(a) A member insurer may offset against its premium taxes an assessment described in § 31-5406(h) to the extent of 10% of the amount of the assessment for each of the 10 calendar years following the year in which the assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against the premium taxes for the year it ceases doing business.

(b) Any sums which are acquired by refund, pursuant to § 31-5406(f) from the Association by member insurers, and which theretofore have been offset against premium taxes as provided in subsection (a) of this section, shall be paid by member insurers to the District of Columbia in accordance with requirements of the District of Columbia Department of Finance and Revenue. The Association shall notify the Commissioner that the refunds have been made.

(July 22, 1992, D.C. Law 9-129, § 11, 39 DCR 4036; May 21, 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Mar. 24, 1998, D.C. Law 12-81, § 31(b), 45 DCR 745.)

Cross references. — Premium tax liability offsets, see § 31-205.

Prior Codifications. — 1981 Ed., § 35-1950.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 12-81. — For legislative history of D.C. Law 12-81, see His-

torical and Statutory Notes following § 31-5405.

References in text. — Pursuant to the Office of the Chief Financial Officer's "Notice of Public Interest" published in the April 18, 1997, issue of the District of Columbia Register (44 DCR 2345) the Office of Tax and Revenue assumed all of the duties and functions previously performed by the Department of Finance and Revenue, as set forth in Commissioner's Order 69-96, dated March 7, 1969. This action was made effective January 22, 1997, nunc pro tunc.

§ 31-5411. Miscellaneous.

(a) Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b)(1) Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved in discussing the activities of the Association in carrying out its powers and duties under § 31-5405.

(2) Records of negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction.

(3) Nothing in this subsection shall limit the duty of the Association to render a report of its activities under this section.

(c)(1) For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent

insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to § 31-5405(m).

(2) Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter.

(3) For the purposes of this subsection, assets attributable to covered policies are that proportion of the assets which the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contribution of the respective parties, including the Association, the shareholders, and policyholders of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until the total amount of valid claims of the Association, with interest, for funds expended in carrying out its powers and duties under § 31-5405 with respect to the insurer have been fully recovered by the Association.

(e)(1) If an order for liquidation or rehabilitation of an insurer domiciled in the District of Columbia has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during 5 years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) through (4) of this subsection.

(2) No distribution shall be recoverable if the insurer shows that, when paid, the distribution was lawful and reasonable, and that the insurer did not know, and could not reasonably have known, that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3)(A) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he or she received.

(B) Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he or she would have received if they had been paid immediately.

(C) If 2 or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be

jointly and severally liable for any resulting deficiency in the amount recoverable from the insolvent affiliate.

(July 22, 1992, D.C. Law 9-129, § 12, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1951. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5412. Examination of the Association; annual report.

(a) The Association shall be subject to examination and regulation by the Mayor.

(b) The Board of Directors shall submit to the Mayor each year, not later than 120 days after the end of the Association's fiscal year, a financial report in a form approved by the Mayor and a report of its activities during the preceding fiscal year.

(July 22, 1992, D.C. Law 9-129, § 13, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1952. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5413. Tax exemptions.

The Association shall be exempt from payment of all fees and all taxes levied by the District of Columbia.

(July 22, 1992, D.C. Law 9-129, § 14, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1953. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5414. Immunity.

(a) There shall be no liability on the part of, and no cause of action shall arise against, any member insurer or its agents or employees, the Association or its agents or employees, members of the Board of Directors, or the Mayor or the Mayor's representatives, for any action or omission by them in performance of their powers and duties under this chapter, except in the case of willful misconduct, gross negligence, or criminal activity on the part of these persons.

(b) The immunity established by subsection (a) of this section shall extend to the participation in any organization of 1 or more state associations of similar purposes and to any organization and its agents or employees.

(July 22, 1992, D.C. Law 9-129, § 15, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1954. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5415. Stay of proceedings; reopening default judgments.

(a) All proceedings in which the insolvent insurer is a party in any court in the District of Columbia shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties.

(b) As to judgment under any decision, order, verdict, or finding based on default, the Association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

(July 22, 1992, D.C. Law 9-129, § 16, 39 DCR 4036.)

Prior Codifications. — 1981 Ed., § 35-1955. legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 9-129. — For

§ 31-5416. Prohibited advertisement of Association act in insurance sale; notice to policyholders.

(a)(1) No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the District of Columbia Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter.

(2) This subsection shall not apply to the Association or any other entity which does not sell or solicit insurance.

(b)(1) Within 180 days of July 22, 1992, the Association shall prepare a summary document describing the general purposes and current limitations of this chapter, which document shall be submitted to the Mayor for approval.

(2) Sixty days after the summary document is approved by the Mayor, no insurer may deliver a policy or contract described in § 31-5402(b)(1) to a policy or contract holder unless the summary document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except as provided in subsection (d) of this section.

(3) The delivery or contents or interpretation of the summary document shall not mean that either the policy or the contract or the holder of either would be covered in the event of the impairment or insolvency of a member insurer.

(4) The summary document shall be revised by the Association as amendments to this chapter may require.

(5) Failure to receive this document does not give the policy holder,

contract holder, certificate holder, or insured any greater rights than the rights stated in this chapter.

(c) The summary document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Mayor shall promulgate rules establishing the form and content of the disclaimer, which at a minimum shall:

(1) State the name and address of the Association and the Commissioner of Insurance and Securities [Commissioner of the Department of Insurance, Securities, and Banking];

(2) Prominently warn the policy or contract holder that the Association may not cover the policy, or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the District of Columbia;

(3) State that the insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer; and

(5) Provide additional information as directed by the Mayor.

(d) No insurer or agent may deliver a policy or contract described in § 31-5402(b)(1) and excluded under § 31-5402(b)(2)(A) from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Life and Health Insurance Guaranty Association. The Mayor, by rule, shall specify the form and content of the notice.

(July 22, 1992, D.C. Law 9-129, § 17, 39 DCR 4036; May 21, 1997, D.C. Law 11-268, § 10(u), 44 DCR 1730.)

Prior Codifications. — 1981 Ed., § 35-1956.

Legislative history of Law 9-129. — For legislative history of D.C. Law 9-129, see Historical and Statutory Notes following § 31-5401.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5401.

CHAPTER 55. PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION.

Sec.	Sec.
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31-5502. Applicability.	31-5510. Prevention of insolvencies.
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31-5508. Effect of paid claims.	

§ 31-5501. Definitions.

For the purposes of this chapter, the term:

- (1) "Account" means any 1 of the 3 accounts created by § 31-5503.
- (2) "Affiliate" means a person who, directly or indirectly, through 1 or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31st of the year next preceding the date the insurer becomes an insolvent insurer.
- (3) "Association" means the District of Columbia Insurance Guaranty Association created pursuant to § 31-5503.
- (4) "Claimant" means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- (5) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.
- (6) "Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this chapter applies issued by an insurer, if such an insurer becomes an insolvent insurer after October 21, 1993, and:
 - (A) The claimant or insured is a resident of the District at the time of the insured event, provided that for entities other than an individual, the principal place of business of the claimant or insured is located in the District at the time of the insured event; or
 - (B) The property from which the claim arises is permanently located in the District. The term "covered claim" shall not include any amount awarded as punitive or exemplary damages, sought as a return of premium under any retrospective rating plan, or due any reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries or otherwise.
- (7) "District" means the District of Columbia.

(8) "Insolvent insurer" means an insurer licensed to transact insurance in the District of Columbia, either at the time the policy was issued or when the insured event occurred, and against whom an order of liquidation with a finding of insolvency has been entered after October 21, 1993, by a court of competent jurisdiction in the insurer's state of domicile or of the District under § 31-1316, and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(9) "Member insurer" means any person who:

(A) Writes any kind of insurance to which this chapter applies under § 31-5502, including the exchange of reciprocal or interinsurance contracts; and

(B) Is licensed to transact insurance in the District.

(10) "Net direct written premiums" means direct gross premiums written in the District on insurance policies to which this chapter applies, less return premiums and dividends paid or credited to policyholders on the direct business. The term "net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(11) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(Oct. 21, 1993, D.C. Law 10-51, § 2, 40 DCR 6120; May 16, 1995, D.C. Law 10-255, § 33, 41 DCR 5193.)

Section references. — This section is referred to in § 31-5503.

Prior Codifications. — 1981 Ed., § 35-3901.

Legislative history of Law 10-51. — D.C. Law 10-51, the "Property and Liability Insurance Guaranty Association Act of 1993," was introduced in Council and assigned Bill No. 10-134, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-96 and transmitted to both Houses of Congress for its review. D.C. Law 10-51 became effective on October 21, 1993.

Legislative history of Law 10-255. — Law 10-255, the "Technical Amendments Act of 1994," was introduced in Council and assigned Bill No. 10-673, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 21, 1994, and July 5, 1994, respectively. Signed by the Mayor on July 25, 1994, it was assigned Act No. 10-302 and transmitted to both Houses of Congress for its review. D.C. Law 10-255 became effective May 16, 1995.

Delegation of Authority. — Delegation of authority pursuant to D.C. Law 10-51, the Property and Liability Insurance Guaranty Association Act of 1993, see Mayor's Order 94-54, March 7, 1994 (41 DCR 1433).

§ 31-5502. Applicability.

This chapter shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- (1) Life, annuity, health, or disability insurance;
- (2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;
- (3) Fidelity or surety bonds, or any other bonding obligations;
- (4) Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- (5) Insurance of warranties or service contracts;

- (6) Title insurance;
- (7) Ocean marine insurance;
- (8) Any transaction or combination of transactions between a person, including affiliates of such a person, and an insurer, including affiliates of such an insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or
- (9) Any insurance provided by or guaranteed by government.

(Oct. 21, 1993, D.C. Law 10-51, § 3, 40 DCR 6120.)

Section references. — This section is referred to in § 31-5501.

Prior Codifications. — 1981 Ed., § 35-3902.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5503. Creation of the Association.

There is created a nonprofit unincorporated legal entity to be known as the District of Columbia Insurance Guaranty Association. All insurers defined as member insurers in § 31-5501(9) shall be and remain members of the Association as a condition of their authority to transact insurance in the District. The Association shall perform its functions under a plan of operation established and approved under § 31-5506 and shall exercise its powers through a board of directors established under § 31-5504. For purposes of administration and assessment, the Association shall be divided into 3 separate accounts:

- (1) The workmen's compensation insurance account;
- (2) The automobile insurance account; and
- (3) The account for all other insurance to which this chapter applies.

(Oct. 21, 1993, D.C. Law 10-51, § 4, 40 DCR 6120.)

Section references. — This section is referred to in § 31-5501.

Prior Codifications. — 1981 Ed., § 35-3903.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5504. Board of directors.

(a) The board of directors of the Association shall consist of not fewer than 5 nor more than 9 persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the Mayor. Vacancies on the board shall be filled for the remainder of the term by a majority vote of the remaining board members subject to the approval of the Mayor. If no members are selected within 60 days after October 21, 1993, the Mayor may appoint the initial members of the board of directors.

(b) In approving selections to the board of directors, the Mayor shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board of directors may be reimbursed from the assets of

the Association for expenses incurred by them as members of the board of directors.

(Oct. 21, 1993, D.C. Law 10-51, § 5, 40 DCR 6120.)

Section references. — This section is referred to in §§ 31-5503 and 31-5506.

Prior Codifications. — 1981 Ed., § 35-3904.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5505. Powers and duties of the Association.

(a) The Association shall:

(1) Be obligated to pay covered claims existing prior to the determination of the insolvency arising within 30 days after the determination of insolvency, or before the policy expiration date if less than 30 days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the determination. The obligation shall extend to covered claims reported pursuant to an optional extended period to report claims sold to the insured by the liquidator. The obligation as to covered claims shall be satisfied by paying to the claimant an amount as follows:

(A) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(B) An amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium; or

(C) An amount not exceeding \$300,000 per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the Guaranty Fund after the earlier of the final date for the filing of claims against the liquidator or receiver of an insolvent insurer or 18 months after the order of liquidation. The Association shall pay only that amount of each unearned premium which is in excess of \$100;

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) Allocate claims paid and expenses incurred among the 3 accounts separately, and assess member insurers, separately for each account, amounts necessary to pay the obligations of the Association under paragraph (1) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this chapter. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each

member insurer shall be notified of the assessment not later than 30 days before it is due. No member insurer may be assessed in any one year on any account an amount greater than 2% of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it deems reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such a payment will not reduce capital or surplus below required minimums. These payments shall be refunded to those companies receiving larger assessments by virtue of such a deferment, or at the election of any company, credited against future assessments. Each member insurer may set off, against any assessment, authorized payments made on covered claims and expenses incurred in the payment of these claims by the member insurer if they are chargeable to the account for which the assessment is made;

(4) Investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. The Association may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested;

(5) Notify those persons the Mayor directs under § 31-5507(b)(1);

(6) Handle claims through its employees or through 1 or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Mayor, but the designation may be declined by a member insurer; and

(7) Reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and shall pay the other expenses of the Association authorized by this chapter.

(b) The Association may:

(1) Employ or retain those persons necessary to handle claims and perform other duties of the Association;

(2) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to those contracts necessary to carry out the purposes of this chapter;

(5) Perform any other acts necessary or proper to effectuate the purposes of this chapter; and

(6) Refund to the member insurers, in proportion to the contribution of each member insurer to that account, that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.

(Oct. 21, 1993, D.C. Law 10-51, § 6, 40 DCR 6120.)

Section references. — This section is referred to in § 31-5506.

Prior Codifications. — 1981 Ed., § 35-3905.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5506. Plan of operation.

(a)(1) The Association shall submit to the Mayor a plan of operations, and any amendments thereto, necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Mayor.

(2) If the Association fails to submit a suitable plan of operation within 90 days following October 21, 1993, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Mayor shall, after notice and hearing, issue those reasonable rules necessary or advisable to effectuate the provisions of this chapter. These rules shall continue in force until modified by the Mayor or superseded by a plan submitted by the Association and approved by the Mayor.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the Association under § 31-5505 will be performed;

(2) Establish procedures for handling assets of the Association;

(3) Establish the amount and method of reimbursing members of the board of directors under § 31-5504;

(4) Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of claims shall be periodically submitted to the Association or similar organization in another jurisdiction by the receiver or liquidator;

(5) Establish regular places and times for meetings of the board of directors;

(6) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;

(7) Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Mayor within 30 days after the action or decision;

(8) Establish the procedures whereby selections for the board of directors will be submitted to the Mayor; and

(9) Contain additional provisions necessary and proper for the execution of the powers and duties of the Association.

(d) The plan of operation may provide that any or all powers and duties of the Association, except those under § 31-5505(a)(3) and (b)(2), are delegated to a corporation, association, or other organization which performs, or will perform, functions similar to those of this Association or its equivalent in 2 or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Mayor, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

(Oct. 21, 1993, D.C. Law 10-51, § 7, 40 DCR 6120.)

Section references. — This section is referred to in § 31-5503.

Prior Codifications. — 1981 Ed., § 35-3906.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5507. Powers and duties of the Mayor.

(a) The Mayor shall:

(1) Notify the Association of the existence of an insolvent insurer not later than 3 days after he or she receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction; and

(2) Upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer.

(b) The Mayor may:

(1) Require that the Association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this chapter. Notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation in the District shall be sufficient;

(2) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in the District of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Mayor may levy a fine on any member insurer which fails to pay an assessment when due. Such a fine shall not exceed 5% of the unpaid assessment per month, except that no fine shall be less than \$100 per month; or

(3) Revoke the designation of any servicing facility if the Mayor finds claims are being handled unsatisfactorily.

(c) Any final action or order of the Mayor under this chapter shall be subject to judicial review in accordance with § 2-510.

(Oct. 21, 1993, D.C. Law 10-51, § 8, 40 DCR 6120.)

Section references. — This section is referred to in § 31-5505.

Prior Codifications. — 1981 Ed., § 35-3907.

Legislative history of Law 10-51. — For legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

§ 31-5508. Effect of paid claims.

(a) Any person recovering under this chapter shall be deemed to have assigned his or her rights under the policy to the Association to the extent of his or her recovery from the Association. Every insured or claimant seeking the protection of this chapter shall cooperate with the Association to the same extent as that person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except those causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as provided in subsection (b) of this section. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association shall not operate to reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(b) The Association shall have the right to recover from the following persons the amount of any covered claim paid on behalf of such a person pursuant to the chapter:

(1) Any insured whose net worth on December 31st of the year next preceding the date the insurer becomes an insolvent insurer exceeds \$50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter; and

(2) Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this chapter.

(c) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another jurisdiction. The court having jurisdiction shall grant these claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the assets of the insolvent insurer. The expenses of the Association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(d) The Association shall periodically file, with the receiver or liquidator of the insolvent insurer, statements of the covered claims paid by the Association and estimates of anticipated claims on the Association which shall preserve the rights of the Association against the assets of the insolvent insurer.

(Oct. 21, 1993, D.C. Law 10-51, § 9, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3908. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For 5501.

§ 31-5509. Nonduplication of recovery.

(a) Any person having a claim against an insurer under any provision in an insurance policy, other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his or her right under such a policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under such an insurance policy.

(b) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the Association of the place of residence of the insured, except that if it is a first-party claim for damage to property with a permanent location, he or she shall seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, he or she shall seek recovery first from the Association of the residence of the claimant. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(Oct. 21, 1993, D.C. Law 10-51, § 10, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3909. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For 5501.

CASE NOTES

In general.

A defendant tortfeasor whose liability insurer is insolvent does not have the right to require the plaintiff to exhaust his potentially applicable uninsured motorist (UM) insurance before the plaintiff enforces his judgment against the defendant, where the District of Columbia Insurance Guaranty Association (DCIGA) has elected to honor the insolvent insurer's coverage obligations to the defendant without requiring such exhaustion; only the DCIGA, itself, has the right to require a plaintiff to exhaust other insurance coverage and to reduce its own exposure to the extent of such other coverage. *Mosley v. Welch*, 830 A.2d 1246, 2003 D.C. App. LEXIS 539 (2003).

The Property and Liability Insurance Guaranty Association Act (IGA) provides a mechanism for the District of Columbia Insurance Guaranty Association (DCIGA) to pay claims against insurers that become insolvent; if an insurer becomes insolvent, the DCIGA steps in to act as if it were the insolvent insurer. *Mosley v. Welch*, 830 A.2d 1246, 2003 D.C. App. LEXIS 539 (2003).

Non-duplication provision of the Property and Liability Insurance Guaranty Association

Act (IGA) requires that a claimant with an alternative source of insurance coverage for a covered claim must first exhaust that alternative source before seeking compensation from the District of Columbia Insurance Guaranty Association (DCIGA), and that the DCIGA's obligation be reduced by the amount of duplicate coverage of the covered claim from alternative sources of insurance. *Mosley v. Welch*, 830 A.2d 1246, 2003 D.C. App. LEXIS 539 (2003).

Under the principle that where an injured plaintiff has alternative sources of insurance covering the same claim as the claim against the insolvent insurer, the nonduplication provision requires the plaintiff to exhaust the solvent policy and deduct the amount recovered from the obligation due by the Property and Liability Insurance Guaranty Association Act (IGA), an important implication is that a plaintiff's solvent insurer is stuck with the loss up to the limit of the insolvent insurer's coverage obligation and is not subrogated to the plaintiff's claim against the tortfeasor whose insurer became insolvent, except insofar as the solvent insurer's payments exceed the insolvent insurer's obligation. *Mosley v. Welch*, 830 A.2d 1246, 2003 D.C. App. LEXIS 539 (2003).

§ 31-5510. Prevention of insolvencies.

To aid in the detection and prevention of insurer insolvencies:

(1) The board of directors may, upon majority vote:

(A) Make recommendations to the Mayor for the detection and prevention of insurer insolvencies; and

(B) Respond to requests by the Mayor to discuss and make recommendations regarding the status of any member insurer whose financial condition may be hazardous to policyholders or the public. The recommendations shall not be considered public documents.

(2) The board of directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of the insolvency, based on the information available to the Association, and submit the report to the Mayor.

(Oct. 21, 1993, D.C. Law 10-51, § 11, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3910. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For

§ 31-5511. Examination of the Association.

The Association shall be subject to examination and regulation by the Mayor. The board of directors shall submit, not later than March 30th of each year, a financial report for the preceding calendar year in a form approved by the Mayor.

(Oct. 21, 1993, D.C. Law 10-51, § 12, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3911. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For

§ 31-5512. Tax exemption.

The Association shall be exempt from payment of all fees and all taxes levied by the District, except taxes levied on real or personal property.

(Oct. 21, 1993, D.C. Law 10-51, § 13, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3912. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For

§ 31-5513. Recognition of assessments in rates.

The rates and premiums charged for insurance policies to which this chapter applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the Association by the member insurer less any amounts returned to the member insurer by the Association, and these rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

(Oct. 21, 1993, D.C. Law 10-51, § 14, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3913. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For 5501.

§ 31-5514. Immunity from liability.

There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, or the Mayor or his or her representatives for any action taken or any failure to act by them in the performance of their powers and duties under this chapter.

(Oct. 21, 1993, D.C. Law 10-51, § 15, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3914. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For 5501.

§ 31-5515. Stay of proceedings; access to records.

(a) All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in the District of Columbia shall be stayed for 6 months, and any additional time thereafter as may be determined by the court, from the date the insolvency is determined or an ancillary proceeding is instituted in the District, whichever is later, to permit proper defense by the Association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the Association, either on its own behalf or on behalf of the insured, may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits.

(b) The liquidator, receiver, or statutory successor of an insolvent insurer covered by this chapter shall permit access by the board of directors or its authorized representative, to any of the insolvent insurer's records which are necessary for the board of directors in carrying out its functions under this chapter with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board of directors, or its representative, with copies of the records upon the request by the board and at the expense of the board.

(Oct. 21, 1993, D.C. Law 10-51, § 16, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., § 35-3915. legislative history of D.C. Law 10-51, see Historical and Statutory Notes following § 31-5501.

Legislative history of Law 10-51. — For 5501.

SUBTITLE X. SECURITIES.

CHAPTER 56. SECURITIES.

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Subchapter I. Definitions and Rules of Construction.

§ 31-5601.01. Definitions.

For the purposes of this chapter, the term:

- (1) "Accredited investor" shall have the same meaning as in section 2(a)(15) of the Securities Act of 1933, approved May 27, 1933 (48 Stat. 74; 15

U.S.C. § 77b(a)(15)), or any other person that the Securities and Exchange Commission may so designate by rule, regulation, or order.

(1A) “Advertisement” means a publicly disseminated, written, or printed communication, including by radio, television, Internet, or other public media, used in connection with a sale or purchase, or an offer to sell or purchase, a security.

(2) “Affiliate” of, or a person “affiliated” with, a specified person, means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the person specified.

(3)(A) “Agent” means an individual, other than a broker-dealer, who represents a broker-dealer or issuer in effecting, or attempting to effect, purchases or sales of securities. The term “agent” shall not include:

(i) An individual who represents a broker in effecting transactions in the District of Columbia (“District”) limited to transactions described in section 15(h)(2) of the Securities Exchange Act of 1934 [15 U.S.C. § 78o(h)(2)];

(ii) An individual who represents an issuer in effecting transactions in a security exempted by § 31-5604.01(1), (2), (3), (4), (5), (6), (7), (8), (9), or (10);

(iii) An individual who represents an issuer in effecting transactions exempted by § 31-5604.02;

(iv) An individual who represents an issuer in effecting a transaction in a covered security as described in section 18(b)(3) and (b)(4)(D) of the Securities Act of 1933 [15 U.S.C. § 77r];

(v) An individual who represents an issuer in effecting transactions with existing employees, partners, or directors of the issuer if no commission or other remuneration is paid or given, directly or indirectly, for soliciting a person in the District; or

(vi) A person not within the intent of this paragraph as the Commissioner may, by rule or order, determine.

(B) A partner, including a general partner, officer, or director of a broker-dealer or issuer, or a person occupying a similar status or performing similar functions, is an agent only if (i) the person otherwise comes within this definition, and (ii) any compensation that he or she receives is directly or indirectly related to purchases or sales of securities.

(4) “Broker-dealer” means a person engaged in the business of effecting offers, purchases, or sales in securities for the account of others or for his or her own account. The term “broker-dealer” shall not include:

(A) An agent;

(B) An issuer, except when effecting purchases, offers, or sales other than with respect to the offer or sale of the issuer’s own securities;

(C) A depository institution to the extent that the depository institution is a bank under section 3(a)(4)(B) and (C) of the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78c(a)(4)(B) and (C)); or

(D) A person who has no place of business in the District if:

(i) The person effects, whether acting for itself or as trustee, transactions in the District exclusively with or through the issuers of the securities

involved in the transactions; a depository institution; another broker-dealer; an insurance company; an investment company as defined in the Investment Company Act of 1940; a pension or profit-sharing trust; or other financial institution or institutional investor; or

(ii) The person is licensed under the securities law of a state in which the person maintains a place of business and the person offers and sells in the District to a person who is an existing customer of the person.

(4A) "Canadian broker-dealer" means a broker-dealer that has its principal office in a province or territory of Canada.

(5) "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

(6) "Commodity Exchange Act" means the Commodity Exchange Act, approved September 21, 1922 (42 Stat. 998; 7 U.S.C. § 1 et seq.).

(7) "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

(8) "Department" means the Department of Insurance, Securities, and Banking.

(9)(A) "Depository institution" means:

(i) A person that is organized, chartered, or holds an authorization certificate under the laws of a state or of the United States to receive deposits, including a savings, share, certificate, or deposit account, and that is supervised and examined for the protection of depositors by an official or agency of a state or the United States; and

(ii) A trust company or other institution that is authorized by federal or state law to exercise fiduciary powers of the type that a national bank is permitted to exercise under the authority of the Comptroller of the Currency and is supervised and examined by an official or agency of a state or the United States.

(B) The term "depository institution" shall not include an insurance company or other organization primarily engaged in the insurance business or a Morris Plan bank, industrial loan company, or a similar bank or company unless its deposits are insured by a federal agency.

(10) "Federal covered adviser" means a person who is registered, or required to be registered, under section 203 [§ 31-5602.03] of the Investment Advisers Act of 1940. The term "federal covered adviser" shall not include a person who is not an investment adviser as defined under paragraph 17(B)(ii) through (xiii) of this section.

(11) "Federal covered security" means a security which is a covered security under section 18(b) of the Securities Act of 1933 [15 U.S.C. § 77r] or the rules and regulations promulgated thereunder.

(12) "Filed" means the actual delivery of a document or application to the Commissioner or designee of the Commissioner or to the principal office of the Commissioner.

(13) "Financial or institutional investor" means any of the following, whether acting for itself or others in a fiduciary capacity:

- (A) A depository institution;
 - (B) An insurance company;
 - (C) A separate account of an insurance company;
 - (D) An investment company registered under the Investment Company Act of 1940;
 - (E) A business development company as defined in the Investment Company Act of 1940;
 - (F) An employee pension, profit-sharing, or benefit plan if:
 - (i) The plan has total assets in excess of \$5 million; or
 - (ii) Its investment decisions are made by a named fiduciary, as defined in the Employee Retirement Income Security Act of 1974, that is either a broker-dealer registered under the Securities Exchange Act of 1934, an investment adviser registered or exempt from registration under the Investment Advisers Act of 1940, a depository institution, or an insurance company;
 - (G) A “qualified institutional buyer” as defined in SEC Rule 144A, 17 C.F.R. § 230.144A;
 - (H) A broker-dealer;
 - (I) An accredited investor as defined in SEC Rule 501(a), 17 C.F.R. § 230.501(a);
 - (J) A limited liability company with net assets of at least \$500,000.
 - (K) Repealed.
- (14) “Fraud”, “deceit”, and “defraud” are not limited to common law fraud or deceit.
- (15) “Guaranteed” means guaranteed as to payment of all, or substantially all, of principal and interest or dividends.
- (16) “Insured” means insured as to payment of all, or substantially all, of principal and interest or dividends.
- (17)(A) “Investment adviser” means a person who, for compensation (i) engages in the business of advising others as to the value of securities or as to the advisability of investing in, purchasing, or selling securities, or (ii) as a part of a regular business, issues or promulgates analyses or reports concerning securities. The term “investment adviser” shall include financial planners or other persons who, as an integral component of other financially related services, provide investment advisory services to others for compensation, or as a part of a business, hold themselves out as providing investment advisory services to others for compensation.
- (B) The term “investment adviser” shall not include:
- (i) A federal covered adviser;
 - (ii) An investment adviser representative;
 - (iii) A depository institution or a person employed by, or directly associated with, a depository institution;
 - (iv) A lawyer, accountant, engineer, insurance agent or broker, or teacher whose performance of investment advisory services is solely incidental to the practice of the person’s profession;
 - (v) A broker-dealer or agent whose performance of investment advisory services is solely incidental to the conduct of business as a broker-dealer and who receives no special compensation for the investment advisory services;

(vi) A publisher, employee, or columnist of a bona fide newspaper, magazine, or business or financial publication or service, whether communicated in printed form, by electronic means, or otherwise, with a regular paid circulation;

(vii) A publisher of a securities advisory newsletter, whether communicated in printed form, by electronic means, or otherwise, with a regular paid circulation who does not provide advice to subscribers on the basis of their specific investment situations;

(viii) An author of material included in a newspaper, magazine, publication, or newsletter who is not otherwise an investment adviser or investment adviser representative as defined under this section;

(ix) A person who provides investment advisory services solely while acting as an investment banker or business broker on behalf of one or more parties to, and in connection with, a transaction or proposed transaction for the transfer of a controlling interest in a business enterprise;

(x) An official, employee, or representative of the United States, a state, a political subdivision of a state, or an agency or a corporate or other instrumentality of the United States or a state, while acting in such person's official capacity on behalf of such entity;

(xi) A person excluded from the definition of "investment adviser" under § 31-5602.02(a)(11)(A) through (F) of the Investment Advisers Act of 1940;

(xii) A licensed real estate broker or salesperson whose advice to clients relates only to the investment in, or acquisition of, real property; and

(xiii) Any other person or class of persons not within the intent of this paragraph as the Commissioner, by rule or order, may designate.

(18) "Investment adviser representative" means:

(A) With respect to an investment adviser licensed or required to be licensed under this chapter, a partner, officer, director, or person occupying a similar status or performing similar functions, or other individual employed by or associated with an investment adviser, except clerical or administrative personnel, who performs any of the following functions:

(i) Makes any recommendations or otherwise renders advice regarding securities;

(ii) Manages accounts or portfolios of clients;

(iii) Determines which recommendation or advice regarding securities should be given;

(iv) Solicits, offers, or negotiates for the sale of, or sells, investment advisory services; or

(v) Supervises employees who perform any of the foregoing functions;

(B) With respect to a federal covered adviser, an individual employed by, or associated with, a federal covered adviser who is an "investment adviser representative" and who has a "place of business" in the District, as those terms are defined by rules promulgated by the Securities and Exchange Commission.

(19) "Investment Advisers Act of 1940" means the Investment Advisers Act of 1940, approved August 22, 1940 (54 Stat. 847; 15 U.S.C. § 80b-1 et seq.).

(20) "Investment Company Act of 1940" means the Investment Company Act of 1940, approved August 22, 1946 (54 Stat. 789; 15 U.S.C. § 80a-1 et seq.).

(21) "Issuer" means a person who issues, or proposes to issue, a security; provided, that with respect to certificates of deposit, voting-trust certificates, collateral-trust certificates, or certificates of interest or shares in an unincorporated investment trust not having a board of directors or persons performing similar functions or of the fixed, restricted management, or unit type, the term "issuer" means the person performing the acts and assuming the duties of depositor or manager under the provisions of the trust or other agreement or instrument under which the security is issued.

(22) "Non-issuer transaction" means a transaction not directly or indirectly for the benefit of the issuer.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint-stock company, a limited liability company, a trust where the interests of the beneficiaries are evidenced by a security, an unincorporated organization, a government, or a political subdivision of a government.

(24) "Price amendment" means the final federal amendment which includes a statement of: the offering price; underwriting and selling discounts or commissions; amount of proceeds; conversion rates; call prices; and other matters dependent upon the offering price.

(25) "Promoter" includes:

(A) A person who, acting alone or in concert with one or more other persons, takes the entrepreneurial initiative in founding or organizing the business or enterprise of an issuer;

(B) An officer or director owning securities of an issuer or a person who owns, beneficially or of record, 10% or more of a class of securities of the issuer if the officer, director, or person acquires any of those securities in a transaction within 3 years before the filing by the issuer of a registration statement under this chapter and the transaction does not possess the indicia of arms-length bargaining; and

(C) A member of the immediate family of a person identified in subparagraphs (A) or (B) of this paragraph if the family member receives securities of the issuer from that person in a transaction within 3 years before the filing by the issuer of a registration statement under this chapter and the transaction does not possess the indicia of arms-length bargaining.

(26) "Public Utility Holding Company Act of 1935" means the Public Utility Holding Company Act of 1935, approved August 26, 1935 (49 Stat. 838; 15 U.S.C. § 79a et seq.).

(27) "Sale" or "sell" includes every contract to sell, exchange, or dispose of a security or interest in a security for value. In this context:

(A) "Offer" or "offer to sell" includes every attempt or offer to dispose of, or solicitation of an offer to buy, a security or interest in a security for value;

(B) "Offer to purchase" includes every attempt or offer to obtain, or solicitation of an offer to sell, a security or interest in a security for value, but the term shall not include a transaction that is subject to section 14(d) of the Securities Exchange Act of 1934 [15 U.S.C. § 78n];

(C) A security given or delivered with, or as a bonus on account of, a

purchase of securities or any other thing is considered to constitute part of the subject of the purchase and to have been offered and sold for value;

(D) A gift of assessable stock is deemed to involve an offer and sale;

(E) A sale or offer of a warrant or right to purchase or subscribe to another security of the same or another issuer, or a sale or offer of a security which gives the holder a present or future right or privilege to convert into another security of the same or another issuer, shall be considered to include an offer of the other security; and

(F) The terms “offer”, “offer to sell”, “sale”, and “sell” shall not include:

(i) The creation of a security interest or a loan;

(ii) A stock dividend, whether the corporation distributing the dividend is the issuer of the stock or not, if nothing of value is given by stockholders for the dividend other than the surrender of a right to a cash or property dividend when each stockholder may elect to take the dividend in cash or property or in stock;

(iii) An act incident to a vote by security holders, pursuant to the certificate of incorporation or the applicable corporation statute or other controlling statute, a partnership agreement, or the controlling agreement among security holders, on a merger; triangular merger; exchange of securities for securities; consolidation; reclassification of securities; reorganization; or sale of corporate assets in consideration of the issuance of securities of another person other than an individual;

(iv) An act incident to a judicially approved reorganization in which a security is issued in exchange for one or more bona fide outstanding securities, claims, or property interests, or partly in such exchange and partly for cash; or

(v) An act as to which the Commissioner finds, by rule or order, that application of this paragraph is not necessary or appropriate for the protection of investors, and the finding is consistent with the public interest and the purposes fairly intended by the policy and provisions of this chapter.

(28) “Securities Act of 1933” means the Securities Act of 1933, approved May 27, 1933 (48 Stat. 74; 15 U.S.C. § 77a et seq.).

(29) “Securities Exchange Act of 1934” means the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78a et seq.).

(30) “Securities and Exchange Commission” means the United States Securities and Exchange Commission.

(31) “Security” means any note; stock; treasury stock; bond; debenture; evidence of indebtedness; certificate of interest or participation in a profit-sharing agreement; a limited partnership interest; collateral-trust certificate; preorganization certificate or subscription; transferable share; investment contract; voting-trust certificate; certificate of deposit for a security; fractional undivided interest in an oil, gas, or other mineral lease or in payments out of production under a lease, right, or royalty; a put, call, straddle, or option entered into a national securities exchange relating to foreign currency; a put, call, straddle, or option on a security, certificate of deposit, or group or index of securities, including an interest in or based on the value of any of the foregoing; or an interest or instrument commonly known as a security; or certificate of interest or participation in, temporary or interim certificate for, receipt for,

whole or partial guarantee of, or warrant or right to subscribe to or purchase, any of the foregoing. The term “security” shall not include:

(A) An insurance or endowment policy or annuity contract under which an insurance company promises to pay a fixed sum of money in a lump sum, periodically for life, or for some other specified period; or

(B) An interest in a contributory or non-contributory pension or welfare plan subject to the Employee Retirement Income Security Act of 1974, approved September 2, 1974 (88 Stat. 832; 29 U.S.C. § 1001 et seq.).

(32) “Self-regulatory organization” means a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 [15 U.S.C. § 78f]; a national securities association of brokers and dealers registered under section 15A of the Securities Exchange Act of 1934 [15 U.S.C. § 78o-3]; the Municipal Securities Rulemaking Board established under section 15B(b)(1) of the Securities Exchange Act of 1934 [15 U.S.C. § 78o-4]; a clearing agency registered under section 17A of the Securities Exchange Act of 1934 [15 U.S.C. § 78q-1]; or a futures association under section 21 of the Commodity Exchange Act [7 U.S.C. § 21].

(33) “State” means a state, territory, or possession of the United States, and Puerto Rico.

(34) “Underwriter” means a person who has purchased from an issuer with a view to, or sells for an issuer in connection with, the distribution of a security; participates, or has a direct or indirect participation in, such undertaking; or participates, or has a participation in, the direct or indirect underwriting of such undertaking. The term “underwriter” shall not include a person whose interest is limited to a commission from an underwriter or dealer not in excess of the usual and customary distributor’s or seller’s commission. As used in this paragraph, the term “issuer” shall include a person directly or indirectly controlling, or controlled by, the issuer or a person under direct or indirect common control with the issuer.

(Oct. 26, 2000, D.C. Law 13-203, § 101, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(a), 49 DCR 4238; Oct. 19, 2002, D.C. Law 14-213, § 22, 49 DCR 8140; June 11, 2004, D.C. Law 15-166, § 4(hh), 51 DCR 2817.)

Effect of amendments. — D.C. Law 14-150 rewrote par. (1); added par. (1A); in par. (3)(A)(ii), substituted “(8), (9), or (10);” for “(8) or (9);”; in par. (4)(C), substituted “to the extent that the depository institution is a bank under section 3(a)(4)(B) and (C) of the Securities Exchange Act of 1934, approved June 6, 1934 (48 Stat. 881; 15 U.S.C. § 78c(a)(4)(B) and (C)); or” for “; or”; in par. (4)(D)(i), substituted “financial institution or institutional investor” for “financial institution or institutional buyer”, and made a nonsubstantive change; in par. (4)(D)(ii), deleted “and whose residence is not in the District”; added par. (4A); in par. (13)(J), made a nonsubstantive change; repealed par. (13)(K); in par. (21), substituted “security; provided, that with” for “security, except that: (A) with”, made a nonsubstantive change, and repealed subpar. (B).

D.C. Law 14-213, in par. (31)(A), inserted a comma following “lump sum”.

D.C. Law 15-166, in pars. (5) and (8), substituted “Department of Insurance, Securities, and Banking” for “Department of Insurance and Securities Regulation”.

Emergency legislation. — For temporary (90 day) amendment of section, see § 4(hh) of Consolidation of Financial Services Emergency Amendment Act of 2004 (D.C. Act 15-381, February 27, 2004, 51 DCR 2653).

Legislative history of Law 13-203. — Law 13-203, the “Securities Act of 2000,” was introduced in Council and assigned Bill No. 13-678, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 26, 2000, and July 11, 2000, respectively. Signed by the Mayor on August 11, 2000, it was

assigned Act No. 13-436 and transmitted to both Houses of Congress for its review. D.C. Law 13-203 became effective on October 26, 2000.

Legislative history of Law 14-150. — Law 14-150, the “Securities Amendment Act of 2002”, was introduced in Council and assigned Bill No. 14-256, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second

readings on March 5, 2002, and April 9, 2002, respectively. Signed by the Mayor on April 24, 2002, it was assigned Act No. 14-328 and transmitted to both Houses of Congress for its review. D.C. Law 14-150 became effective on June 25, 2002.

Legislative history of Law 14-213. — For Law 14-213, see notes following § 31-903.

Legislative history of Law 15-166. — For Law 15-166, see notes following § 31-1004.

§ 31-5601.02. Purpose and coordination with federal law.

(a) The purpose of this chapter is to protect investors and maintain public confidence in securities markets while avoiding unreasonable burdens on participants in capital markets. This chapter is remedial in nature and is to be broadly construed to effectuate its purposes.

(b) This chapter and the rules and regulations promulgated hereunder shall be coordinated with the federal acts and statutes to which references are made in this chapter and the rules and regulations promulgated under those federal acts and statutes to the extent that coordination is consistent with both the purposes and the provisions of this chapter.

(Oct. 26, 2000, D.C. Law 13-203, § 102, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Subchapter II. Broker-Dealers, Agents, Investment Advisers and Investment Adviser Representatives.

§ 31-5602.01. Licensing of broker-dealer and agent.

(a) No person shall transact business in the District of Columbia (“District”) as a broker-dealer or agent unless the person is licensed or exempt from licensure under this chapter.

(b) No broker-dealer or issuer shall employ an agent to represent the broker-dealer or issuer unless the agent is licensed or exempt from licensure under this chapter. The license of an agent shall not be effective during any period when the agent is not associated with a specified broker-dealer licensed under this chapter or with a specified issuer.

(c) No agent shall at any time represent more than one broker-dealer or issuer without the written consent of each broker-dealer or issuer. If an agent begins or terminates an association with a broker-dealer or issuer, or begins or terminates those activities which make the person an agent, the agent and the broker-dealer or issuer shall promptly notify the Commissioner.

(d) Unless sooner terminated under this chapter or renewed, the license of a broker-dealer or agent shall expire on December 31.

(e) No broker-dealer licensed under this chapter shall transact business in the District unless it registers at least one agent with the Department.

(Oct. 26, 2000, D.C. Law 13-203, § 201, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01. **Legislative history of Law 13-203.** — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.02. Licensing of investment adviser and investment adviser representative.

(a) No person shall transact business in the District as an investment adviser or as an investment adviser representative unless the person is licensed, or exempt from licensure, under this chapter, or the person has no place of business in the District, and:

(1) The person's only clients in the District are other investment advisers, federal covered advisers, broker-dealers, investment companies as defined in the Investment Company Act of 1940, depository institutions, insurance companies, employee benefit plans with assets of not less than \$1 million, governmental agencies or instrumentalities (whether acting for themselves or as trustees with investment control), or other institutional investors as are designated by rule or order of the Commissioner; or

(2) During the preceding 12 months, the person has had no more than 5 clients who are residents of the District and are not the types of clients described in paragraph (1) of this subsection.

(b) No person shall:

(1) In the case of a licensed investment adviser, employ an investment adviser representative unless the investment adviser representative is licensed under this chapter; provided, that the license of an investment adviser representative shall not be effective during any period when the investment adviser representative is not employed by a licensed investment adviser; or

(2) In the case of a federal covered adviser, employ, supervise, or associate with an investment adviser representative having a place of business located in the District unless the investment adviser representative is licensed under this chapter or is exempt from licensure.

(c) When an investment adviser representative begins or terminates employment with a licensed investment adviser or federal covered adviser, the investment adviser or the investment adviser representative shall promptly notify the Commissioner.

(d) Except for advisers whose only clients are those described in subsection (a) of this section, a federal covered adviser shall not conduct advisory business in the District unless the federal covered adviser complies with § 31-5602.03(e).

(e) Unless sooner terminated under this chapter or renewed, the license of an investment adviser and investment adviser representative, and the notice filing of each federal covered adviser, shall expire on December 31.

(f) No investment adviser representative may be registered with more than one investment adviser unless the investment advisers which employ or associate with the investment adviser representative are under common ownership or control.

(Oct. 26, 2000, D.C. Law 13-203, § 202, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.03. License and notice filing procedure.

(a) A broker-dealer, agent, investment adviser, or investment adviser representative may obtain an initial or renewal license by filing with the Commissioner an application and the consent to service of process required under § 31-5607.06. The application shall contain whatever information the Commissioner may, by rule, require, including:

- (1) The applicant's form and place of organization;
- (2) The applicant's proposed method of doing business;
- (3) The qualifications and business history of the applicant, and in the case of a broker-dealer or investment adviser, the qualifications and business history of any partner, officer, or director; any person occupying a similar status or performing similar functions; or any person directly or indirectly controlling the broker-dealer or investment adviser;
- (4) Any injunction or administrative order or conviction of a misdemeanor involving a security or any aspect of the securities business and any conviction of a felony;
- (5) The applicant's financial condition and history for 10 years; and
- (6) If the applicant is an investment adviser, any information to be furnished or disseminated to a client or prospective client.

(b) If no denial order is in effect and no proceeding is pending under § 31-5602.07, the license shall become effective no later than noon on the 30th day after the application is filed. If the application is incomplete, the Commissioner may request additional information from the applicant and delay the effective date for 30 days from the date of receipt of the requested information. The Commissioner shall consider the application withdrawn if the requested information is not received by noon on the 90th day after the request.

(c) The licensing of a broker-dealer shall constitute the licensing of any agent who is a partner, officer, or director, or a person occupying a similar status or performing similar functions. The licensing of an investment adviser shall constitute the licensing of any investment adviser representative who is a partner, officer, or director, or a person occupying a similar status or performing similar functions.

(d)(1) Except for a federal covered adviser whose only clients are those described in § 31-5602.02(a), a person shall not transact business as a federal covered adviser unless the person has made a notice filing with the Commissioner, which filing shall consist of:

- (A) A copy of those documents that have been filed with the Securities and Exchange Commission that the Commissioner may, by rule or order, require;
- (B) The consent to service of process required under § 31-5607.06; and
- (C) A fee that the Commissioner may, by rule, prescribe.

(2) A notice filing shall be effective from the date of its receipt by the Commissioner until the following December 31st and may be renewed by filing with the Commissioner those documents that have been filed with the

Securities and Exchange Commission that the Commissioner requires, by rule or order and a fee to be established by the Commissioner.

(3) The Commissioner may, by rule or order, require a federal covered adviser who has made a notice filing under this section to file with the Commissioner copies of any amendments to documents filed with the Securities and Exchange Commission.

(4) A notice filing may be terminated by a filing notice of termination with the Commissioner. A notice of termination shall be effective upon receipt by the Commissioner.

(e)(1) An applicant for an initial or renewal license as a broker-dealer or agent shall pay a license filing fee as the Commissioner may, by rule, require. The applicant shall not be entitled to a refund of the fee in the event of a withdrawal or denial of the application or the failure to provide additional information requested by the Commissioner.

(2) An applicant for an initial or renewal as an investment adviser or an investment adviser representative who is required to obtain a license shall pay a license filing fee as the Commissioner may, by rule, require. The applicant shall not be entitled to a refund of the fee in the event of a withdrawal or denial of the application or the failure to provide additional information requested by the Commissioner.

(3) A person acting as a federal covered adviser in the District, except a federal covered adviser whose only clients are those described in § 31-5602.02(a), shall pay an initial and renewal notice filing fee as the Commissioner may, by rule, require.

(f) The Commissioner may, by rule or order, require a minimum net capital for a licensed broker-dealer, subject to the limitations of section 15 of the Securities Exchange Act of 1934 [15 U.S.C. § 78o], and establish minimum financial requirements for an investment adviser, subject to the limitations of section 222 of the Investment Advisers Act of 1940 [15 U.S.C. § 80b-18a]. The Commissioner may prescribe different requirements for those investment advisers who maintain custody of clients funds or securities or have discretionary authority over these funds or securities and those investment advisers who do not have such custody or authority.

(g)(1) The Commissioner may, by rule or order:

(A) Require a licensed broker-dealer or agent, or a licensed investment adviser or representative who has custody of or discretionary authority over client funds or securities, to post a surety bond or deposit cash or any other equivalent form of security in such amounts as the Commissioner may require, subject to the limitations of section 15 of the Securities Exchange Act of 1934 [15 U.S.C. § 78o] in the case of a broker-dealer, and section 222 of the Investment Advisers Act of 1940 [15 U.S.C. § 80b-18a] in the case of an investment adviser; and

(B) Determine the conditions of such bond or equivalent security.

(2) A surety bond or equivalent form of security shall provide that:

(A) No action may be maintained to enforce a liability on the bond or equivalent form of security unless brought within 2 years after the contract of sale or other act on which the action is based; and

(B) The liability of the surety on the bond or equivalent form of security to all persons aggrieved shall not exceed, in the aggregate, the penal sum of the bond.

(Oct. 26, 2000, D.C. Law 13-203, § 203, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.04. Post-licensing requirements.

(a)(1) A licensed broker-dealer shall make and keep such accounts, correspondence, memoranda, papers, books, and other records as the Commissioner may, by rule, require.

(2) The authority of the Commissioner to adopt rules under paragraph (1) of this subsection shall be subject to the limitations of section 15 of the Securities Exchange Act 1934 [15 U.S.C. § 78o].

(3) A licensed investment adviser shall make and keep such accounts, correspondence, memoranda, papers, books, and other records as the Commissioner may by rule require.

(4) The authority of the Commissioner to adopt rules under paragraph (3) of this subsection shall be subject to the limitations of section 222 of the Investment Advisers Act of 1940 [15 U.S.C. § 80b-18a].

(b)(1) With respect to investment advisers, the Commissioner may, by rule or order, require that certain information be furnished or disseminated as appropriate in the public interest or for the protection of investors and advisory clients.

(2) Information furnished to clients or prospective clients of a licensed investment adviser that complies with the Investment Advisers Act of 1940 and the rules promulgated under that Act may be used in whole or partial satisfaction of the requirement in paragraph (1) of this subsection.

(c) A licensed broker-dealer or investment adviser shall file such financial reports as the Commissioner may, by rule or order, prescribe, except as provided by section 15 of the Securities Exchange Act 1934 [15 U.S.C. § 78o] in the case of a broker-dealer and section 222 of the Investment Advisers Act of 1940 [15 U.S.C. § 80b-18a] in the case of an investment adviser.

(d) If the information contained in any document filed with the Commissioner is, or becomes, inaccurate or incomplete in any material respect, a licensed broker-dealer or investment adviser shall promptly file a correcting amendment with the Commissioner, and a federal covered adviser shall file a correcting amendment when required to do so with the Securities and Exchange Commission.

(Oct. 26, 2000, D.C. Law 13-203, § 204, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.05. Licensing of successor firms.

(a) A licensed broker-dealer or investment adviser or federal covered adviser shall file an application for the license or a notice filing, as applicable, of a successor, whether or not the successor is then in existence. There shall be no fee for the license or notice filing of the successor.

(b) If a broker-dealer or investment adviser succeeds to, and continues the business of, a licensed broker-dealer or investment adviser, or a federal covered adviser succeeds to and continues the business of, a federal covered adviser who has made a notice filing, and the successor files an application for a license or a notice filing, as applicable, within 30 days after the succession, the license or notice filing of the predecessor remains effective as the license or notice filing of the successor for 60 days after the succession.

(c) The licensing of a licensed agent of the broker-dealer filing an application under subsections (a) or (b) of this section continues without a separate filing or fee upon the licensing of the successor.

(Oct. 26, 2000, D.C. Law 13-203, § 205, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.06. Power of inspection, examination and audit.

(a) The Commissioner may, in a manner reasonable under the circumstances, examine, audit, or inspect the books and records, within or without the District, of a licensed broker-dealer, agent, investment adviser, or investment adviser representative as the Commissioner considers necessary or appropriate in the public interest or for the protection of investors or to determine compliance with this chapter. All licensed broker-dealers, agents, and investment advisers shall make their books and records available to the Commissioner in legible form.

(b) The Commissioner may copy records, or require a licensed person to copy records and provide the copies to the Commissioner, to the extent and in a manner reasonable under the circumstances.

(c) The Commissioner may impose a reasonable fee for the expense of conducting an examination, inspection, or audit under this section.

(d) For the purpose of avoiding unnecessary duplication of examinations, the Commissioner may cooperate with the securities administrators of other states, the Securities and Exchange Commission, or any self-regulatory organization.

(Oct. 26, 2000, D.C. Law 13-203, § 206, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.07. Grounds for denial, suspension, or revocation.

(a) The Commissioner may, by order, deny, suspend, or revoke a license if the Commissioner finds that the order is in the public interest and the applicant or licensed person or, in the case of a broker-dealer or investment adviser, a partner, officer, or director, or a person occupying a similar status or performing similar functions, or a person directly or indirectly controlling the broker-dealer or investment adviser:

(1) Has filed an application for licensure with the Commissioner which, as of its effective date, or as of any date after filing in the case of an order denying effectiveness, was incomplete in any material respect or contained a statement that was, in light of the circumstances under which it was made, false or misleading with respect to any material fact;

(2) Has violated or failed to comply with this chapter, the District of Columbia Securities Act, approved August 30, 1964 (78 Stat. 620; § 3-3601 et seq.) ("1964 Act"), the Investment Advisers Act of 1992, effective March 17, 1993 (D.C. Law 9-216; § 3-3701 et seq.) ("1992 Act"), or any insurance law in the District, or a rule or order promulgated under this chapter, the 1964 Act, the 1992 Act, or any insurance law in the District;

(3) Has been convicted within the past 10 years of a felony or of an offense that:

(A) Involves making a false statement under oath, making a false report, bribery, perjury, theft, or attempt or conspiracy to commit any of these offenses;

(B) Arises out of the conduct of business as, employment by, or association with, a broker-dealer, investment adviser, depository institution, insurer, agency, fiduciary, accountant, real estate broker, or an entity or person required to be registered under the Commodity Exchange Act; or

(C) Involves larceny, theft, robbery, extortion, forgery, counterfeiting, fraudulent concealment, embezzlement, fraudulent conversion, misappropriation of funds or securities, or an attempt or conspiracy to commit any of these offenses;

(4) Is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice (A) as an investment adviser, underwriter, broker-dealer, or as an affiliated person or employee of an investment company, depository institution, or insurance company, or from (B) in connection with any of the foregoing activities or any aspect of the securities business;

(5) Is the subject of an order of the Commissioner denying, suspending, or revoking the person's license as a broker-dealer, agent, investment adviser, or investment adviser representative;

(6) Is the subject of an order entered within the past 10 years by a securities administrator or any other financial services regulator of another state, by the Securities and Exchange Commission, or by the National Association of Securities Dealers, suspending, denying or revoking the license or registration as a broker-dealer, investment adviser, investment adviser

representative, or agent, or the substantial equivalent of these terms as defined in this chapter, or any other financial services license or registration;

(7) Is the subject of an order by the Commodity Futures Trading Commission denying, suspending, or revoking registration under the Commodity Exchange Act; is the subject of a United States Postal Service fraud order; or is suspended or expelled from membership in, or association with a member of, a self-regulatory organization;

(8) Is the subject of an order of a court of competent jurisdiction finding that the person has willfully violated the Securities Act of 1933, the Securities Exchange Act of 1934, the Investment Advisers Act of 1940, the Investment Company Act of 1940, the Commodity Exchange Act, or the securities or insurance law of another state, but only if the act constituting the violation of that state's law would violate this chapter if the act occurred in the District;

(9) Has engaged in an unethical or dishonest practice in the securities business as the Commissioner may, by rule, define;

(10) Never had or has failed to maintain the minimum net capital required by SEC Rule 15c3-1, 17 C.F.R. § 240.15c3-1.

(11) Is determined by the Commissioner, in accordance with § 31-5602.08, not to be qualified because of lack of training, experience, knowledge of the securities or insurance business, or failure to comply with the continuing education requirements established by the New York Stock Exchange, other self-regulatory agency, or National Association of Securities Dealers;

(12) Has failed reasonably to supervise a sales representative or employee;

(13) Has failed to pay the proper filing fee within 30 days after being notified by the Commissioner of a deficiency; provided, that the Commissioner shall vacate an order under this paragraph when the deficiency is corrected; or

(14) In the conduct of his or her affairs under the license, the licensee has shown himself or herself to be incompetent, untrustworthy, or financially irresponsible.

(b) The Commissioner shall not begin a proceeding to revoke or suspend a license under this section on the basis of a fact or transaction known to the Commissioner when the license became effective unless the proceeding is begun within 90 days after the license became effective.

(c) If the Commissioner finds that an applicant or licensed person is no longer in existence, has ceased to do business as a broker-dealer, agent, investment adviser, or investment adviser representative, is adjudicated mentally incompetent or subjected to the control of a committee, conservator, or guardian, or cannot be located after reasonable search, the Commissioner may, by order, deny the application or revoke the license.

(Oct. 26, 2000, D.C. Law 13-203, § 207, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(b), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (a)(11), substituted “established by the New York Stock Exchange, other self-regulatory agency, or” for “established by the”; and rewrote subsec. (a)(10) which had read as

follows: “(10) Is insolvent, either because liabilities exceed assets or because obligations cannot be met as they mature, but the Commissioner may not enter an order against a broker-dealer or investment adviser under this

paragraph without a finding of insolvency as to the broker-dealer or investment adviser;"

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.08. Denial, suspension, or revocation on grounds of lack of qualification.

A determination by the Commissioner that an applicant or licensed person lacks qualification shall be made subject to the following limitations and considerations:

(1) The Commissioner may not enter an order against a broker-dealer on the basis of the lack of qualification of a person other than the broker-dealer if the broker-dealer is an individual.

(2) The Commissioner may not enter an order against an investment adviser on the basis of the lack of qualification of a person other than the investment adviser if the investment adviser is an individual.

(3) The Commissioner may not enter an order solely because of lack of experience of the applicant or licensed person if the applicant or licensed person is qualified by training or knowledge.

(4) An agent who will work under the supervision of a licensed broker-dealer need not have the same qualifications as a broker-dealer and an investment adviser representative who will work under the supervision of a licensed investment adviser need not have the same qualifications as an investment adviser.

(5) An investment adviser is not qualified solely on the basis of experience as a broker-dealer or agent. If the Commissioner finds an applicant for initial or renewal licensure as a broker-dealer is not qualified as an investment adviser, the Commissioner may, by order, condition the applicant's licensure as a broker-dealer upon the broker-dealer not transacting business in the District as an investment adviser.

(6) The Commissioner may, by rule, provide for an examination, which may be written, oral, or both, to be taken by any class of, or all, applicants. The Commissioner may, by rule or order, waive the examination requirement as to a person or class of persons if the Commissioner determines that the examination is not necessary or appropriate in the public interest or for the protection of investors.

(Oct. 26, 2000, D.C. Law 13-203, § 208, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.09. Withdrawal.

(a) Withdrawal from licensing as a broker-dealer, agent, investment adviser, or investment adviser representative shall be effective 30 days after the receipt by the Commissioner of an application to withdraw or within any shorter period the Commissioner, by order, determines, unless:

(1) A revocation or suspension proceeding is pending when the withdrawal application is filed; or

(2) A proceeding to revoke or suspend or to impose conditions upon the withdrawal is instituted within 30 days after the withdrawal application is filed.

(b) If a proceeding is pending or instituted, the withdrawal shall be effective at the time and upon the conditions that the Commissioner, by order, determines. If no proceeding is pending or instituted and the withdrawal becomes effective, the Commissioner may institute a proceeding under § 31-5602.07 within one year after the withdrawal became effective and enter an order as of the last date on which the license was effective.

(Oct. 26, 2000, D.C. Law 13-203, § 209, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5602.10. Limited registration of Canadian broker-dealers and agents.

(a) A Canadian broker-dealer may be licensed under this section if the broker-dealer:

(1) Has its principal office located in a province or territory of Canada that provides at least equivalent registration for a broker-dealer that is resident in the United States;

(2) Is resident in Canada and does not have an office or physical presence in the United States;

(3) Files an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

(4) Files a written consent to service of process under § 31-5607.06;

(5) Is registered as a broker or dealer in good standing in the jurisdiction from which the broker-dealer is effecting transactions in the District and files evidence of the registration; and

(6) Is a member of a self-regulating organization or stock exchange in Canada.

(b) An agent may be licensed under this section if the agent represents a Canadian broker-dealer that is licensed under this section, and the agent:

(1) Files an application in the form required by the jurisdiction in which the broker-dealer has its principal office;

(2) Files a written consent to service of process under section § 31-5607.06; and

(3) Is registered and files evidence of good standing in the jurisdiction from which the agent is effecting transactions into the District.

(c) If no denial order is in effect and no proceeding is pending under § 31-5602.07, the license shall become effective no later than noon on the 30th day after an application is filed. If the application is incomplete, the Commissioner may request additional information from the applicant and delay the effective date for 30 days from the date of receipt of the request for information.

(d)(1) A broker-dealer licensed under this section may effect transactions in

securities with or for or induce or attempt to induce the purchase or sale of a security by a person from Canada who is:

(A) Temporarily resident in the District and with whom the Canadian broker-dealer had a bona fide broker-dealer-client relationship before the person entered the United States; or

(B) A resident in the District and whose transactions are in a self-directed tax-advantaged retirement plan in Canada of which the person is the holder or contributor.

(2) A Canadian broker-dealer or agent licensed under this section shall not effect transactions in the District unless it is:

(A) Authorized in paragraph (1) of this subsection;

(B) With or through:

(i) The issuers of the securities involved in the transactions;

(ii) Other broker-dealers; or

(iii) Banks, savings institutions, trust companies, insurance companies, investment companies as defined in the Investment Company Act of 1940, approved August 22, 1946 (54 Stat. 789; 15 U.S.C. § 80a-1 et seq.), pension or profit-sharing trusts, or other financial institutions or institutional investor, whether acting for themselves or as trustees; or

(C) As otherwise permitted by the Commissioner in any rule or order.

(e) An agent licensed under this section may effect transactions in securities in the District of Columbia as permitted for the Canadian broker-dealer licensed under this section.

(f) A Canadian broker-dealer licensed under this section shall:

(1) Maintain provincial or territorial registration and membership in good standing in a self-regulating organization or stock exchange;

(2) Provide the Commissioner on request with books and records relating to its business in the District as a broker-dealer;

(3) Inform the Commissioner promptly of any criminal action taken against the broker-dealer or of any finding or sanction imposed on the broker-dealer as a result of regulatory action, including that of a self-regulating organization, involving fraud, theft, deceit, misrepresentation, or similar conduct; and

(4) Disclose to its clients in the District that the broker-dealer and its agents are not subject to the full regulatory requirements of the District.

(g) An agent of a Canadian broker-dealer licensed under this section shall:

(1) Maintain provincial or territorial registration in good standing; and

(2) Inform the Commissioner promptly of any criminal action taken against the agent or of any finding or sanction imposed on the broker-dealer or agent as a result of regulatory action, including that of a self-regulating organization, involving fraud, theft, deceit, misrepresentation, or similar conduct.

(h) Renewal applications for Canadian broker-dealers and agents under this section shall be filed annually before December 1 and may be made by filing the most recent renewal application, if any, filed in the jurisdiction in which the broker-dealer has its principal office or, if a renewal application is not required, the most recent application filed under subsection (a)(1) or (b)(1) of this section.

(i) An applicant for an initial license or renewal under this section shall pay the fee for broker-dealers and agents required by rules issued by the Commissioner.

(j) A Canadian broker-dealer or agent licensed under this section and acting in accordance with the limitations in subsection (d) or (e) of this section shall be exempt from all of the requirements of this chapter, except the provisions of subchapters V and VI.

(Oct. 26, 2000, D.C. Law 13-203, § 210, as added June 25, 2002, D.C. Law 14-150, § 2(c), 49 DCR 4238.)

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5602.11. Continuing education.

The Commissioner may, by rule or order, establish continuing education requirements for investment adviser representatives.

(Oct. 26, 2000, D.C. Law 13-203, § 211, as added June 25, 2002, D.C. Law 14-150, § 2(d), 49 DCR 4238.)

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Subchapter III. Registration of Securities.

§ 31-5603.01. Registration requirement.

No person shall offer or sell a security in the District unless the security is registered under this chapter, the security or transaction is exempt under § 31-5604.01 or § 31-5604.02, or the security is a federal covered security.

(Oct. 26, 2000, D.C. Law 13-203, § 301, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01. 13-203 provided: “Titles III and IV shall apply as of June 1, 2001.”

Editor’s notes. — Section 806 of D.C. Law

§ 31-5603.02. Registration by notification.

(a) The following securities may be registered by notification, whether or not the securities are also eligible for registration by coordination under § 31-5603.03:

(1) A security whose issuer, and any predecessor (by merger, consolidation or acquisition of assets), has been in continuous operation for at least 5 years if:

(A) There has been no default within the past 3 calendar years in the payment of principal, interest, or dividends on any security of the issuer with a fixed maturity or a fixed interest or dividend provision; and

(B) The issuer and any predecessor during the past 3 calendar years

have had average net earnings, determined in accordance with generally accepted accounting principles, which:

(i) Are applicable to all securities without a fixed maturity or a fixed interest or dividend provision outstanding on the date that the registration statement is filed and equal at least 5% of the amount of these outstanding securities, as measured by the maximum cash offering price or the market price on a day selected by the registrant, within 30 days before the date of filing the registration statement, whichever is higher, or book value, on a day selected by the registrant within 90 days of the date of filing the registration statement, to the extent that there is not a readily determinable market price or a cash offering price; or

(ii) If the issuer and any predecessor has not had a security of the type specified in sub-subparagraph (i) of this subparagraph outstanding for 3 full calendar years, equal at least 5% of the amount, as measured in sub-subparagraph (i) of this subparagraph, of all securities which will be outstanding if all the securities being offered or proposed to be offered, whether or not they are proposed to be registered or offered in the District, are issued; and

(2) A security, other than a certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease, registered for nonissuer distribution if:

(A) A security of the same class has ever been registered under this chapter; or

(B) The security being registered was originally issued pursuant to an exemption under this chapter.

(b) In addition to the information specified in § 31-5603.06(c) and the consent to service of process required under § 31-5607.06, a registration statement under this section shall contain the following information and be accompanied by the following documents,:

(1) A statement demonstrating eligibility for registration by notification;

(2) With respect to the issuer and any significant subsidiary:

(A) The name, address, and form of organization;

(B) The state or jurisdiction of its organization and the date of its organization; and

(C) The general character and location of its business;

(3) With respect to a person on whose behalf a part of the offering is to be made in a non-issuer distribution:

(A) The person's name and address;

(B) The amount of the issuer's securities held by the person as of the date of the filing of the registration statement; and

(C) A statement of the person's reasons for making the offering;

(4) A description of the security being registered;

(5) The information and documents specified in § 31-5603.04(b)(2), (4), (7), (8), (9), (10), and (12);

(6) A balance sheet of the issuer as of a date within 4 months before the filing of the registration statement;

(7) A summary of earnings:

(A) For each of the 2 calendar years preceding the date of the balance sheet and for any period between the close of the last calendar year and the date of the balance sheet; or

(B) For the period of existence of the issuer and any predecessor, if less than 2 years; and

(8) Two copies of the prospectus required by subsection (c) of this section.

(c)(1) As a condition of registration under this section, a prospectus containing any designated part of the information specified in subsection (b) of this section shall be sent or given to each person to whom an offer is made before or concurrently with the first to occur of:

(A) The first written offer to the person, other than by means of a public advertisement, by or for the account of the issuer or any other person on whose behalf the offering is being made, or by any underwriter or broker-dealer who is offering part of an unsold allotment or subscription taken by the underwriter or broker-dealer as a participant in the distribution;

(B) The confirmation of a sale made by or for the account of the person;

(C) Payment under the sale; or

(D) Delivery of the security under the sale.

(2) Paragraph (1)(A) of this subsection may be satisfied by the use of a preliminary prospectus, so designated and bearing the legend which the Commissioner prescribes, if a final prospectus is sent or given to each recipient of the preliminary prospectus before or concurrently with whichever event in paragraph (1)(B), (C), and (D) first occurs.

(d) If a stop order is not in effect and a proceeding is not pending under § 31-5603.06, a registration statement under this section shall become effective at:

(1) Three o'clock p.m. eastern standard time or eastern daylight savings time, as applicable, of the 10th full business day after the filing of the registration statement or the last amendment; or

(2) At any earlier time which the Commissioner determines by rule or order.

(Oct. 26, 2000, D.C. Law 13-203, § 302, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(e), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (b), substituted “31-5603.06(c)” for “31-5603.05(c)”.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5603.03. Registration by coordination.

(a) A security for which a registration statement has been filed under the Securities Act of 1933 in connection with the offering of the security may be registered by coordination.

(b) In addition to the information specified in § 31-5603.06(c) and the consent to service of process required under § 31-5607.06, a registration

statement under this section shall contain the following information and be accompanied by the following documents:

(1) Two copies of the latest prospectus or offering circular filed under the Securities Act of 1933;

(2) If the Commissioner, by rule or order, requires:

(A) A copy of the articles of incorporation and by-laws, or their substantial equivalents, as currently in effect;

(B) A copy of any agreement with or among underwriters;

(C) A copy of any indenture or other instrument governing the issuance of the security to be registered; and

(D) A specimen, copy, or description of the security;

(3) If the Commissioner requests, any other information or copies of any document filed under the Securities Act of 1933; and

(4) An undertaking to forward all future amendments to the federal prospectus, other than an amendment which merely delays the effective date of the registration statement, promptly and not later than the first business day after the day on which they are forwarded to or filed with the Securities and Exchange Commission, whichever occurs first.

(c) A registration statement under this section shall become effective at the time that the federal registration statement becomes effective if all of the following conditions are satisfied:

(1) A stop order is not in effect and a proceeding is not pending under § 31-5603.06;

(2) The registration statement has been on file with the Commissioner for at least 10 business days; and

(3) A statement of the maximum and minimum proposed offering prices and the maximum underwriting discounts and commissions has been on file for 2 full business days, or any shorter period which the Commissioner permits by rule or otherwise, and the offering is made within those limitations.

(d) The registrant shall promptly notify the Commissioner, in writing, facsimile transmission, or other means considered acceptable by the Commissioner, of the date and time when the federal registration statement became effective and the content of the price amendment, if any, and shall promptly file a post-effective amendment containing the information and documents in the price amendment.

(e) Upon failure to receive the required notification and post-effective amendment with respect to the price amendment, the Commissioner may enter a stop order, without notice or hearing, retroactively denying the effectiveness of the registration statement or suspending its effectiveness until there is compliance with subsection (d) of this section if the Commissioner promptly notifies the registrant by telephone or otherwise, and promptly confirms by letter, facsimile transmission, or otherwise if the Commissioner notifies by telephone, of the issuance of the order. If the registrant proves compliance with the requirements of subsection (d) of this section as to notice and post-effective amendment, the stop order shall be void as of the time of its entry.

(f) The Commissioner may, by rule or otherwise, waive either or both of the conditions specified in subsection (c)(2) or (3) of this section.

(g) If the federal registration statement becomes effective before all of the conditions in subsection (c) of this section are satisfied and they are not waived, the registration statement shall become effective when all the conditions are satisfied. If the registrant advises the Commissioner of the date when the federal registration statement is expected to become effective, the Commissioner shall promptly advise the registrant by telephone, facsimile, or otherwise, at the registrant's expense, whether all of the conditions are satisfied and whether the Commissioner then contemplates the institution of a proceeding under § 31-5603.06. This advice by the Commissioner shall not preclude the institution of a proceeding for a stop order suspending the effectiveness of the registration statement.

(h) The Commissioner may, by rule or order, waive or modify the application of a requirement of this section if a provision, or an amendment, repeal, or other alteration of the securities registration provisions, of the Securities Act of 1933, or the regulations adopted thereunder, render the waiver or modification appropriate for further coordination of District and federal law.

(Oct. 26, 2000, D.C. Law 13-203, § 303, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(f), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (b), substituted “31-5603.06(c)” for “31-5603.05(c)”.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5603.04. Registration by qualification.

(a) A security may be registered by qualification.

(b) In addition to the information specified in § 31-5603.06(c) and the consent to service of process required under § 31-5607.06, a registration statement under this section shall contain the following information and be accompanied by the following documents:

(1) With respect to the issuer and any significant subsidiary:

- (A) The name, address, and form of its organization;
- (B) The state or foreign jurisdiction and date of its organization;
- (C) The general character and location of its business;
- (D) A description of its physical properties and equipment;
- (E) A statement of the general competitive conditions in the industry or business in which it is or will be engaged; and

(F) Certified copies of its articles of incorporation;

(2) With respect to every director and officer of the issuer, or person occupying a similar status or performing similar functions:

- (A) The name, address, and principal occupation for the past 5 years;
- (B) The amount of securities of the issuer held by the person as of a specified date within 30 days of the filing of the registration statement;
- (C) The amount of the securities covered by the registration statement to which the person has indicated an intention to subscribe; and
- (D) A description of any material interest in any material transaction

that the person has effected, or proposed to effect, with the issuer or any significant subsidiary of the issuer within the past 3 years;

(3) With respect to persons covered under paragraph (2) of this subsection, the remuneration paid during the past 12 months and estimated to be paid during the next 12 months, directly or indirectly, by the issuer, including all its predecessors, parents, subsidiaries, and affiliates, to all these persons in the aggregate;

(4) With respect to a person owning of record, or beneficially if known, 10% or more of the outstanding shares of any class of equity security of the issuer, the information specified in paragraph (2) of this subsection other than the person's occupation;

(5) With respect to every promoter if the issuer was organized within the past 3 years, the information specified in paragraph (2) of this subsection, any amount paid, or intended to be paid, to the promoter within the 3-year period or intended to be paid to the promoter and a description of the services or other consideration provided in return for the payment;

(6) With respect to a person on whose behalf a part of the offering is to be made in a non-issuer distribution:

(A) The person's name and address;

(B) The amount of securities of the issuer held by the person as of the date of the filing of the registration statement;

(C) A description of any material interest in any material transaction that the person has effected, or proposed to effect, with the issuer or any significant subsidiary of the subsidiary within the past 3 years; and

(D) A statement of the person's reasons for making the offering;

(7)(A) The capitalization and long-term debt, on both a current and pro forma basis, of the issuer and any significant subsidiary, including a description of each security outstanding or being registered or otherwise offered; and

(B) A statement of the amount and kind of consideration, whether in the form of cash, physical assets, services, patents, goodwill, or anything else, for which the issuer or any subsidiary has issued any of its securities within the past 2 years or is obligated to issue any of its securities;

(8)(A) The amount and kind of securities to be offered; the proposed offering price or method by which it shall be computed, and any variation from the offering price at which a proportion of the offering is to be made to a person or class of persons other than the underwriters, with a specification of the person or class; and the basis upon which the offering is to be made if otherwise than for cash;

(B) The estimated aggregate underwriting and selling discounts or commissions and finders' fees, separately stating the amount of cash, securities, contracts, or anything else of value to accrue to the underwriters or finders in connection with the offering, or, if the selling discounts or commissions are variable, the basis of determining them and their maximum and minimum amounts;

(C) The estimated amounts of other selling expenses, including legal, engineering, and accounting charges, the name and address of every underwriter and every recipient of a finder's fee, and a copy of any underwriting or

selling group agreement under which the distribution is to be made or the proposed form of the agreement whose terms have not yet been determined; and

(D) A description of the plan of distribution of securities which are to be offered otherwise than through an underwriter;

(9)(A) The estimated cash proceeds to be received by the issuer from the offering, the purposes for which the proceeds are to be used by the issuer, and the amount to be used for each purpose;

(B) The order or priority in which the proceeds will be used for the purposes stated, the amounts of any funds to be raised from other sources to achieve the purposes stated, and the sources of such funds; and

(C) If any part of the proceeds is to be used to acquire property, including goodwill, otherwise than in the ordinary course of business:

(i) The names and addresses of the vendors;

(ii) The purchase price;

(iii) The names of persons who have received commissions in connection with the acquisition; and

(iv) The amount of the commissions and any other expense in connection with the acquisition, including the cost of borrowing money to finance the acquisition;

(10) A description of stock options or other security options outstanding, or to be created in connection with the offering, and the amount of such options held, or to be held, by a person required to be named in paragraphs (2), (4), (5), (6), or (8) of this subsection and by a person who holds, or will hold, 10% or more, in the aggregate, of any such options;

(11)(A) The dates of, parties to, and general effect, concisely stated of, every management or other material contract made, or to be made, otherwise than in the ordinary course of business if it is to be performed in whole or in part at or after the filing of the registration statement or was made within the past 2 years, together with a copy of the contract; and

(B) A description of any pending litigation or proceeding to which the issuer is a party and which materially affects its business or assets, including any litigation or proceeding known to be contemplated by governmental authorities;

(12) Two copies of any prospectus, pamphlet, circular, form letter, advertisement, or other sales literature intended, as of the effective date, to be used in connection with the offering;

(13) A specimen, copy, or description of the security being registered; a certified copy of the issuer's articles of incorporation and a certified copy of its bylaws, or their substantial equivalents, as currently in effect; and a copy of any indenture or other instrument covering the security to be registered;

(14) A signed or conformed copy of an opinion of counsel as to the legality of the security being registered, with an English translation if it is in a foreign language, which opinion shall state whether the security when sold will be legally issued, fully paid, and non-assessable, and, if a debt security, a binding obligation of the issuer;

(15) The written consent of an accountant, engineer, appraiser, or other person whose profession gives authority to a statement made by the person, if

the person is named as having prepared or certified a report or valuation, other than a public and official document or statement, which is used in connection with the registration statement;

(16) A certified statement of financial condition of the issuer as of a date within 4 months prior to the filing of the registration statement; a balance sheet, profit and loss statement, and analysis of surplus for each of the 3 calendar years preceding the date of the statement of financial condition and for any period between the close of the last calendar year and the date of the statement of financial condition, or for the period of the issuer's and any predecessors existence if less than 3 years, and if any part of the proceeds of the offering is to be applied to the purchase of any business, the same financial statements which would be required if that business were the registrant; and

(17) Any additional information the Commissioner may require by rule or order.

(c) A registration statement under this section shall become effective no later than 60 calendar days after the date of the registration statement or the last statement other than a price amendment is filed if:

(1) No stop order is in effect and no proceeding is pending under § 31-5603.06;

(2) The Commissioner has not ordered under subsection (d) of this section that effectiveness be delayed; and

(3) The registrant has not requested that effectiveness be delayed.

(d) The Commissioner may delay effectiveness for a single period not to exceed 90 days if the Commissioner determines that the registration statement is not complete in all material respects and promptly notifies the registrant of the determination. The Commissioner may delay effectiveness for a single period not to exceed 30 days if the Commissioner determines that delay is necessary, whether or not the Commissioner previously delayed effectiveness under this subsection.

(Oct. 26, 2000, D.C. Law 13-203, § 304, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(g), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (b), substituted "31-5603.06(c)" for "31-5603.05(c)".

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5603.05. Offer and sale of an indefinite amount of securities.

(a) A face-amount certificate company, an open-end management company, a closed-end management company that is not a federal covered security under section 18(b)(1) of the Securities Act of 1933, or a unit investment trust, as those terms are defined in the Investment Company Act of 1940, shall comply with the requirements of this section if the company or trust files:

(1) A notice under § 31-5603.08 of the offer or sale in the District of an

indefinite amount of federal covered securities specified in section 18(b)(2) of the Securities Act of 1933 [15 U.S.C. § 77r]; or

(2) An application to register under § 31-5603.03 the offer or sale in the District of an indefinite amount of securities.

(b)(1) A face-amount certificate company or an open-end management company, at the time of filing, shall pay an initial fee established by the Commissioner.

(2) Within 60 days after the issuer's fiscal year end during which its registration statement is effective or notice required by § 31-5603.08 is filed, a face-amount certificate company or an open-end management company shall:

(A) Pay a fee in an amount established by rule; or

(B) File a report, on a form that the Commissioner, by rule, adopts for the reporting of all sales of securities to persons within the District during the fiscal year, and pay a fee based upon the maximum aggregate offering price at which the securities were sold in the District in accordance with a formula established by rule.

(3)(A) To calculate the net amount due under paragraph (2)(B) of this subsection, the initial fee paid in accordance with paragraph (1) of this subsection shall be deducted from the aggregate fee.

(B) Except as provided in subsection (d) of this section, the aggregate fee due under this subsection may not exceed the maximum aggregate fee established by rule.

(C) If the aggregate fee due under paragraph (2)(B) of this subsection is less than the initial fee, no additional amount shall be payable and no credit or refund shall be allowed or returned.

(c)(1) At the time of the filing, a unit investment trust or a closed-end management company that is not a federal covered security under section 18(b)(1) of the Securities Act of 1933 [15 U.S.C. § 77r] shall pay an initial fee established by rule.

(2) Within 60 days after the anniversary of the date on which the issuer's offer became effective or its notice filed under § 31-5603.08 was accepted, a unit investment trust or closed-end management fund that is not a federal covered security under section 18(b)(1) of the Securities Act of 1933 [15 U.S.C. § 77r] shall:

(A) Pay a fee in an amount established by rule; or

(B) File a report, on a form that the Commissioner, by rule, adopts for the reporting of all sales of securities to persons within the District during the effective period of the registration statement or the acceptance period of the notice filed under § 31-5603.08; and pay a fee based upon the maximum aggregate offering price at which the securities were sold in the District in accordance with a formula established by rule.

(3)(A) To calculate the net amount due under paragraph (2)(B) of this subsection, the initial fee paid in accordance with paragraph (2) of this subsection shall be deducted from the aggregate fee.

(B) Except as provided in subsection (d) of this section, the aggregate fee due under paragraph (2)(B) of this subsection may not exceed the maximum aggregate fee established by rule.

(C) If the aggregate fee under paragraph (2)(B) of this subsection is less than the initial fee, no additional amount shall be payable and no credit or refund shall be allowed or returned.

(d)(1) The Commissioner may, by rule or order, extend the length of the renewal period to a period not exceeding 2 years for the effectiveness of a registered offering or for a notice filed under § 31-5603.08.

(2) If the Commissioner extends a renewal period in excess of one year, the fee shall be prorated for the extended renewal period.

(Oct. 26, 2000, D.C. Law 13-203, § 305, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(h), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (a), substituted “open-end” for “open”; and in subsec. (c)(3)(B)(iii), substituted “(C) If” for “(iii) If”.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5603.06. Provisions applicable to registration generally.

(a) A registration statement may be filed by the issuer, any other person on whose behalf the offering is to be made, or a broker-dealer licensed under this chapter.

(b) A person filing a registration statement shall pay a filing fee in an amount established by rule. If a registration statement is withdrawn or abandoned before the effective date, or if a pre-effective stop order is entered under § 31-5603.06, the Commissioner shall retain the fee.

(c) Every registration statement shall specify:

(1) The amount of securities to be offered in the District;

(2) The states in which a registration statement or similar document in connection with the offering has been or is to be filed; and

(3) Any adverse order, judgment, or decree entered in connection with the offering by the regulatory authorities in any state, by any court, or by the Securities and Exchange Commission.

(d) A document filed under this chapter may be incorporated by reference in the registration statement to the extent that the document is currently accurate.

(e) The Commissioner may, by rule or order, permit the omission of an item of information or document from a registration statement.

(f) In the case of a non-issuer offering, the Commissioner may not require information under § 31-5603.04 unless it is known to the person filing the registration statement or on whose behalf the offering is to be made or can be furnished by the person without unreasonable effort or expense.

(g) The Commissioner may, by rule or order, require as a condition of registration by coordination under § 31-5603.03, and registration by qualification under § 31-5603.04, for an issuer that has no public market for its shares or no significant earnings from continuing operations during the last 5 years or any shorter period of its existence:

(1) That any security to be issued for a consideration substantially

different from the public offering price, or to any person for a consideration other than cash, be deposited in escrow; and

(2) That the proceeds from the sale of the registered security in the District be impounded until the issuer receives a specified amount from the sale of the security either in the District or elsewhere.

(h) The Commissioner may, by rule or order, require as a condition of registration that any security registered by qualification or coordination be sold only on a specified form of subscription or sale contract, and that a signed or conformed copy of each contract be filed with the Commissioner or preserved for a period, not to exceed 3 years, specified in the rule or order.

(i) Except during the time of stop order is in effect under § 31-5603.07, a registration statement shall be effective for one year from its effective date, or any longer period during which the security is being offered or distributed in a non-exempt transaction by or for the account of the issuer or other person on whose behalf the offering is being made, or by any underwriter or broker-dealer who is still offering part of an unsold allotment or subscription taken by the underwriter or broker-dealer as a participant in the distribution.

(j) During the period that a registration statement is effective, the Commissioner may, by rule or order, require the person who filed the registration statement to file reports, not more often than quarterly, to keep reasonably current the information contained in the registration statement and to disclose the progress of the offering.

(k) A registration statement may be amended after its effective date to increase the securities specified to be offered and sold if the public offering price and the underwriters' discounts and commissions are not changed from the respective amounts of which the Commissioner was informed. The amendment shall become effective when the Commissioner so orders. A person filing an amendment shall pay an amendment fee in the amount established by rule. The amendment shall relate back to the date of the sale of the additional securities being registered; provided, that within 6 months of the date of the sale, the amendment is filed and the additional fee is paid.

(l) The Commissioner may, by rule or order, require as a condition of registration under § 31-5603.02, § 31-5603.03 or § 31-5603.04 that a prospectus be sent or given to each person to whom an offer is made in accordance with the prospectus delivery requirements of the Securities Act of 1933. The Commissioner may require that a prospectus containing any part of the information specified in § 31-5603.04(b) be sent or given to each person to whom an offer is made before the sale of the security.

(Oct. 26, 2000, D.C. Law 13-203, § 306, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5603.07. Denial, suspension, and revocation of registration.

(a) The Commissioner may issue a stop order denying effectiveness to, or

suspending or revoking the effectiveness of, a registration statement if the Commissioner finds the order is in the public interest, and:

(1) The registration statement as of its effective date (or any earlier date in the case of an order denying effectiveness), any amendment under § 31-5603.05(k) as of its effective date, or any report under § 31-5603.05(j) is incomplete in any material respect or contains any statement which was, in the light of the circumstances under which it was made, false or misleading with respect to any material fact;

(2) This chapter or any rule, order, or condition lawfully imposed under this chapter has been willfully violated in connection with the offering by:

(A) The person filing the registration statement;

(B) The issuer, any partner, officer, or director of the issuer, any person occupying a similar status or performing similar functions, or any person directly or indirectly controlling or controlled by the issuer, but only if the person filing the registration statement is directly or indirectly controlled by or acting for the issuer; or

(C) An underwriter;

(3) The security registered, or sought to be registered, is the subject of an administrative stop order or similar order or a permanent or temporary injunction of a court of competent jurisdiction entered under a federal or state act applicable to the offering; provided, that the Commissioner shall not:

(A) Institute a proceeding against an effective registration statement under this subsection more than one year from the date of the order or injunction relied on; and

(B) Enter an order under this subsection on the basis of an order or injunction entered under the law of a state unless the order or injunction was based on facts which would constitute a basis for a stop order under this subsection;

(4) The issuer's enterprise or method of business includes, or would include, activities which are illegal where performed;

(5) The offering has worked, or tended to work, a fraud upon purchasers or would so operate;

(6) The offering has been, or would be made, with an unreasonable amount of underwriters' and sellers' discounts, commissions, or other compensation, or promoters' profits or participation, or unreasonable amount or kind of options;

(7) If a security is sought to be registered by notification, it is not eligible for such registration; or

(8) If a security is sought to be registered by coordination, there has been a failure to comply with the undertaking required by § 31-5603.03(b)(4).

(b) If an applicant or registrant has failed to pay the proper filing fee and the Commissioner finds that it is in the public interest, the Commissioner may enter a denial order for a registration statement and shall vacate the order when the deficiency has been corrected.

(c) The Commissioner shall not institute a stop order proceeding against an effective registration statement on the basis of a fact or transaction known to the Commissioner when the registration statement became effective unless the

proceeding is instituted within 30 days after the registration statement became effective.

(d) The Commissioner may, by order, summarily postpone or suspend the effectiveness of the registration statement pending the final determination of a proceeding under this section. Upon the entry of the order, the Commissioner shall promptly notify each person specified in subsection (e) of this section that it has been entered, of the reasons therefor, and that, within 30 days after the receipt of a written request, the matter will be scheduled for hearing. If no hearing is requested and none is ordered by the Commissioner, the order will remain in effect until it is modified or vacated by the Commissioner. If a hearing is requested or ordered, the Commissioner, after notice of an opportunity for hearing to each person specified in subsection (e) of this section, may modify or vacate the order or extend it until final determination.

(e) No stop order may be entered under this section, except the first sentence of subsection (d) of this section, without:

(1) Appropriate prior notice to the applicant or registrant, the issuer, and the person on whose behalf the securities are to be, or have been, offered;

(2) Opportunity for a hearing; and

(3) Written findings of fact and conclusions of law.

(f) The Commissioner may vacate or modify a stop order if he or she finds that the conditions which prompted its entry have changed or it is otherwise in the public interest to do so.

(Oct. 26, 2000, D.C. Law 13-203, § 307, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5603.08. Federal covered securities.

(a) This section shall apply to a federal covered security that is not otherwise exempt from the requirements of § 31-5603.01 pursuant to § 31-5604.01 or § 31-5604.02.

(b) A security that is a federal covered security under section 18(b)(2) of the Securities Act of 1933 may be offered for sale and sold into, from, or within the District upon:

(1)(A) The filing with the Commissioner a copy of the registration statement filed by the issuer with the Securities and Exchange Commission under the Securities Act of 1933; or

(B) In lieu of filing a copy of the registration statement, the filing of a notice as prescribed by the Commissioner by rule or order;

(2) The filing of the consent to service of process required under § 31-5607.06; and

(3) The payment of a filing fee in the amount established by rule, per class, or per series.

(c)(1) A notice filing under this section shall be effective for one year commencing upon the later of the date the notice or registration statement, as applicable, is received by the Commissioner or the date the offering is effective with the Securities and Exchange Commission. A notice filing may be renewed

by filing, before the expiration of an effective notice filing, the documents and fees required by subsection (b) of this section. A renewal notice filing shall be effective upon the expiration of the previous notice filing.

(2) A previously filed consent to service of process may be incorporated by reference in a renewal filing to the extent that the previously filed consent to service of process is currently accurate.

(3) After the initial offer of the federal covered security in the District, all documents that are part of an amendment to a federal registration statement filed with the Securities and Exchange Commission under the Securities Act of 1933 shall be filed promptly with the Commissioner upon request. A notice filing may be terminated by an issuer upon notice to the Commissioner of such termination.

(d) The Commissioner may, by rule or order, require the issuer of a security that is a federal covered security under section 18(b)(4)(D) of the Securities Act of 1933 [15 U.S.C. § 77r] to:

(1) File a notice on a Form D as adopted by the Securities and Exchange Commission;

(2) File the consent to service of process required under § 31-5607.06 no later than 15 days after the first sale in the District of the federal covered security; and

(3) Pay a filing fee in the amount established by rule.

(e) The Commissioner may, by rule or order, require the filing of a document filed with the Securities and Exchange Commission under the Securities Act of 1933 for a security that is a federal covered security under section 18(b)(3) or (4) of the Securities Act of 1933 [15 U.S.C. § 77r] and the payment of a filing fee in the amount established by rule.

(f) Except for a security covered by section 18(b)(1) of the Securities Act of 1933 [15 U.S.C. § 77r], the Commissioner may issue a stop order suspending the offer and sale of a federal covered security in the District if the Commissioner finds the order is in the public interest and there is a failure to comply with a requirement of this section. The Commissioner may, by rule or order, waive any or all of the provisions of this section.

(Oct. 26, 2000, D.C. Law 13-203, § 308, 47 DCR 7837; Oct. 3, 2001, D.C. Law 14-28, § 2902, 48 DCR 6981.)

Effect of amendments. — D.C. Law 14-28, in subsec. (b)(3), deleted “for unit investment trusts” following “series”.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-28. — For Law 14-28, see notes following § 31-2001.

§ 31-5603.09. Withdrawal and abandonment.

(a) A registration statement may be withdrawn, at the discretion of the Commissioner, after receipt by the Commissioner of an application to withdraw, unless a revocation or suspension proceeding is pending when the withdrawal application is filed.

(b) If a proceeding is pending or instituted, withdrawal shall be effective at

the time and upon the conditions that the Commissioner, by order, determines. If no proceeding is pending or instituted and withdrawal becomes effective, the Commissioner may institute a proceeding under § 31-5603.06 and enter an order as of the last date on which the registration was effective.

(c) A registration statement that has not been made effective within one year of the initial filing may be deemed abandoned by the Commissioner.

(Oct. 26, 2000, D.C. Law 13-203, § 309, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Subchapter IV. Exemption from Registration.

§ 31-5604.01. Exempt securities.

The following securities shall be exempt from the requirements of §§ 31-5603.01, 31-5603.07, and 31-5604.05:

(1) A security, including a revenue obligation, issued or guaranteed by the United States; an international agency or corporate or other instrumentality of which the United States and one or more foreign governments are members; a state; a political subdivision of a state; or any agency or corporate or other instrumentality of one or more of the foregoing; or a certificate of deposit for any of the foregoing;

(2) A security issued, insured, or guaranteed by Canada; a Canadian province; a political subdivision of an agency or other instrumentality of one or more of the foregoing; or an foreign government with which the United States currently maintains diplomatic relations, if the security is recognized as a valid obligation by the issuer, insurer, or guarantor.

(3) A security issued by and representing an interest in, or a direct obligation of, or guaranteed by, a depository institution or credit union organized under the laws of the United States or a depository institution or credit union organized and supervised under the laws of any state if the deposit or share accounts of the depository institution or credit union are insured by the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, the National Credit Union Share Insurance Fund, or a successor to one of the foregoing;

(4) A security issued by and representing an interest in, or a direct obligation of, or insured or guaranteed by, an insurance company organized under the laws of any state or the District and authorized to do business in the District; provided, that this exemption shall not apply to an annuity contract, investment contract, or similar security under which the promised payments or rate of return are not fixed in dollars but are substantially dependent upon the investment results of a segregated fund or account invested in securities;

(5) A security issued or guaranteed by a railroad, other common carrier, public utility, or holding company that is:

(A) Subject to the jurisdiction of the Interstate Commerce Commission or a successor agency;

(B) A registered holding company under the Public Utility Holding Company Act of 1935 or a subsidiary of such a company within the meaning of that Act;

(C) Regulated with respect to its rates and charges by a governmental authority of the United States or any state; or

(D) Regulated with respect to the issuance or guarantee of the security by a governmental authority of the United States, any state, the District, Canada, or a Canadian province;

(6)(A) A security which is listed or approved for listing upon notice of issuance on the New York Stock Exchange, the American Stock Exchange, the Philadelphia Stock Exchange, the Midwest Stock Exchange, the Pacific stock exchange, or any other exchange which the Commissioner designates by rule to have substantially the same standards for listing as these exchanges, or designated for trading on the National Association of Securities Dealers Automated Quotation System or any other electronic trading system which the Commissioner designates by rule to have substantially the same standards for listing or trading;

(B) Any other security of the same issuer which is of senior or substantially equal rank;

(C) A security called for by subscription rights or warrants so listed or approved; or

(D) A warrant or right to purchase or subscribe to any of the foregoing;

(7) An option issued by a clearing agency registered under the Securities Exchange Act of 1934, other than an off-exchange futures contract or substantially similar arrangement, if the security, currency, commodity, or other interest underlying the option:

(A) Is registered under § 31-5603.02, § 31-5603.03, or § 31-5603.04;

(B) Is exempt under this section; or

(C) Is not otherwise required to be registered under this chapter;

(8) A security issued by a person organized and operated not for private profit but exclusively for a religious, educational, benevolent, charitable, fraternal, social, athletic, or reformatory purpose or as a chamber of commerce or trade or professional association, and no part of the net earnings of the issuer inures to the benefit of any private shareholder or individual; provided, that at least 10 calendar days before a sale of the security, the person has filed with the Commissioner a notice setting forth the material terms of the proposed sale and copies of any sales and advertising literature to be used and the Commissioner, by order, does not disallow the exemption within the next 5 calendar days;

(9)(A) A promissory note, draft, bill of exchange, or bankers' acceptance that evidences an obligation to pay cash within 9 months after the date of issuance, exclusive of days of grace, that is issued in denominations of at least \$50,000, and that receives a rating in one of the 3 highest rating categories from a nationally recognized statistical rating organization;

(B) A renewal of such an obligation that is likewise limited; or

(C) A guarantee of such an obligation or of a renewal;

(10) A security issued in connection with:

(A) A written compensatory benefit plan, including a stock purchase, savings, option, bonus, stock appreciation, profit sharing, thrift, incentive, pension, or similar employees' benefit plan, and interests in such plans established by one or more of the issuers thereof or its parents or affiliates or controlled subsidiaries, for the participation of their employees, directors, general partners, or trustees if the issuer is a business trust, officers, or consultants or advisers of such issuers or their parents or controlled subsidiaries; provided, that bona fide services are rendered by consultants or advisers and the services are not in connection with the offer and sale of securities in a capital-raising transaction; or

(B) A written contract relating to the compensation of such participating persons;

(11) Equipment trust certificates for equipment leased or conditionally sold to a person if securities issued by the person would be exempt under this section; and

(12) A membership or equity interest in, or a retention certificate or like security given in lieu of a cash patronage dividend issued by, a cooperative organized and operated as a nonprofit membership cooperative under the cooperative laws of the District or any state if not traded to the public.

(13) Repealed.

(Oct. 26, 2000, D.C. Law 13-203, § 401, 47 DCR 7837; Oct. 26, 2001, D.C. Law 14-42, § 29(a), 48 DCR 7612; June 25, 2002, D.C. Law 14-150, § 2(i), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-42 repealed par. (13).

D.C. Law 14-150, in par. (10)(A), substituted "general partners, or" for "general partners"; made nonsubstantive changes in pars. (11) and (12); and repealed par. (13) which was previously repealed by D.C. Law 14-42.

Temporary Repeal of Section For temporary (225 day) repeal of section, see § 2 of Securities Temporary Amendment Act of 2001 (D.C. Law 14-62, February 6, 2002, law notification 49 DCR 2272).

Emergency legislation. — For temporary (90 day) amendment of section, see § 2 of Securities Emergency Amendment Act of 2001 (D.C. Act 14-81, July 9, 2001, 48 DCR 6351).

For temporary (90 day) amendment of section, see § 2 of Securities Legislative Review Emergency Amendment Act of 2001 (D.C. Act 14-180, November 19, 2001, 48 DCR 11066).

For temporary (90 day) amendment of section, see § 2 of Securities Congressional Re-

view Emergency Amendment Act of 2001 (D.C. Act 14-217, December 21, 2001, 49 DCR 390).

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-42. — Law 14-42, the "Technical Correction Amendment Act of 2001", was introduced in Council and assigned Bill No. 14-216, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on June 5, 2001, and June 26, 2001, respectively. Signed by the Mayor on July 24, 2001, it was assigned Act No. 14-107 and transmitted to both Houses of Congress for its review. D.C. Law 14-42 became effective on October 26, 2001.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Editor's notes. — Section 806 of D.C. Law 13-203 provided: "Titles III and IV shall apply as of June 1, 2001."

Section 29(b) of D.C. 14-42 provided: "Subsection (a) of this section repealing par. (13) shall apply as of May 31,

§ 31-5604.02. Exempt transactions.

The following transactions are exempt from §§ 31-5603.01, 31-5603.07, and 31-5604.05:

(1) An isolated nonissuer transaction, whether or not effected through a broker-dealer;

(2) A nonissuer transaction by a licensed agent of a licensed broker-dealer, and a resale transaction by a sponsor of a unit investment trust registered under the Investment Company Act of 1940, in a security of a class that has been outstanding and publicly held for at least 90 days; provided, that at the time of the transaction:

(A) The issuer of the security is actually engaged in business and not in the organizational stage or in bankruptcy or receivership and is not a blank check, blind pool, or shell company whose primary plan of business is to engage in a merger or combination of the business with, or an acquisition of, an unidentified person;

(B) The security is sold at a price reasonably related to the current market price of the security;

(C) The security does not constitute the whole or part of an unsold allotment to, or a subscription or participation by, the broker-dealer as an underwriter of the security;

(D) A nationally recognized securities manual designated by rule or order of the Commissioner or a document filed with the Securities and Exchange Commission which is publicly available through the Securities and Exchange Commission's Electronic Data Gathering and Retrieval System contains:

(i) A description of the business and operations of the issuer;

(ii) The names of the issuer's officers and directors, if any, or, in the case of a non-United States issuer, the corporate equivalents of such persons in the issuer's country of domicile;

(iii) An audited balance sheet of the issuer as of a date within 18 months, or in the case of a reorganization or merger where parties to the reorganization or merger had an audited balance sheet, a pro forma balance sheet as of a date within 18 months;

(iv) An audited income statement for each of the issuer's immediately preceding 2 fiscal years or for the period of existence of the issuer, if in existence for less than 2 years or, in the case of a reorganization or merger where the parties to the reorganization or merger had an audited income statement, a pro forma income statement; and

(E) The issuer of the security has a class of equity securities listed on a national securities exchange registered under the Securities Exchange Act of 1934, or designated for trading on the National Association of Securities Dealers Automated Quotation System or any other electronic trading system which the Commissioner designates by rule to have substantially the same standards for listing or trading, unless:

(i) The issuer of the security is a unit investment trust registered under the Investment Company Act of 1940;

(ii) The issuer of the security has been engaged in continuous business (including predecessors) for at least 3 years; or

(iii) The issuer of the security has total assets of at least \$2 million based on an audited balance sheet as of a date within 18 months or, in the case

of a reorganization or merger where parties to the reorganization or merger had an audited balance sheet, a pro forma balance sheet;

(3) A nonissuer transaction in a security by a licensed agent of a licensed broker-dealer if:

(A) The issuer of the security is actually engaged in business and not in the organizational stage or in bankruptcy or receivership and is not a blank check, blind pool, or shell company whose primary plan of business is to engage in a merger or combination of the business with, or an acquisition of, an unidentified person; and

(B) The security is senior in rank to the common stock of the issuer both as to payment of dividends or interest and upon dissolution or liquidation of the issuer, the security has been outstanding at least 3 years, and the issuer or any predecessors has not defaulted within the current fiscal year or the 3 immediately preceding fiscal years in the payment of a dividend, interest, principal, or sinking fund installment on the security when due and payable;

(4) A nonissuer transaction in an outstanding security if the issuer of the security has a class of securities subject to registration under section 12 of the Securities Exchange Act 1934 [15 U.S.C. § 78l] and has been subject to the reporting requirements of sections 13 or 15(d) of the Securities Exchange Act of 1934 [15 U.S.C. § 78m or 15 U.S.C. § 78o(d)] for not less than 90 days next preceding the transaction, or has filed and maintained with the Commissioner for not less than 90 days preceding the transaction information, in the form that the Commissioner, by rule, specifies, substantially comparable to the information that the issuer would be required to file under section 12(b) or (g) [15 U.S.C. § 78l] of the Securities Exchange Act of 1934 if the issuer had a class of its securities registered under section 12 of the Securities Exchange Act of 1934 [15 U.S.C. § 78l];

(5) A nonissuer transaction in a security that has a fixed maturity or a fixed interest or dividend provision and for which there has been no default in the payment of principal, interest, or dividends on the security during the current fiscal year or within the 3 past years, or, if less than 3 years, during the existence of the issuer and any predecessors;

(6) A nonissuer transaction effected by or through a licensed broker-dealer under an unsolicited order or offer to purchase, if either the confirmation of the transaction delivered to the customer clearly states that the transaction was unsolicited, or the broker-dealer obtains a written acknowledgment signed by the customer that the transaction was unsolicited, and a copy of the confirmation or the acknowledgment is preserved by the broker-dealer for such period as the Commissioner may, by rule, require;

(7) A transaction between the issuer or other person on whose behalf the offering of a security is made and an underwriter, or a transaction among underwriters;

(8) A transaction in a bond or other evidence of indebtedness secured by a real estate mortgage, deed of trust, personal property security agreement, or by an agreement for the sale of real estate or personal property, if the entire mortgage, deed of trust, or agreement, together with all the bonds or other evidences of indebtedness secured thereby, is offered and sold as a unit;

(9) A transaction by an executor, administrator, sheriff, marshal, receiver, trustee in bankruptcy, guardian, or conservator;

(10) A transaction executed by a bona fide secured party without any purpose of evading this chapter;

(11) An offer to sell, or the sale of a security to a financial institution or institutional investor or to a broker-dealer, whether the purchaser is acting for itself or in some fiduciary capacity;

(11A) An offer to sell, or the sale of a security, by an issuer to an accredited investor;

(12)(A) Subject to subparagraph (B) of this paragraph, a transaction pursuant to an offer directed by the offeror to not more than 25 persons, other than those designated in § 31-5602.02(a)(1), in the District during any period of 12 consecutive months, whether or not the offeror, or any of the offerees, is then present in the District at the time of the transaction, if:

(i) The seller reasonably believes that all the purchasers in the District are purchasing for investment; and

(ii) No commission or other remuneration is paid or given directly or indirectly for soliciting a prospective purchaser in the District except to a licensed broker-dealer or a licensed agent.

(B) The Commissioner may, by rule or order, as to a security or transaction or any type of security or transaction, withdraw or further condition this exemption, increase or decrease the number of purchasers permitted, or waive one or more of the conditions in this paragraph;

(13) To the extent permitted by rule or order of the Commissioner, an offer or sale within the District by an issuer now or hereafter exempt from section 5 of the Securities Act of 1933 [15 U.S.C. § 77e] by a rule or regulation adopted by the Securities and Exchange Commission under section 3(b) or section 4(2) of that Act [15 U.S.C. § 77c or 15 U.S.C. § 77d] if the issuer files with the Commissioner a notice of intent to claim exemption under this paragraph, at such time, in such form, and containing such information as the Commissioner determines;

(14) An offer or sale of a preorganization certificate or subscription if:

(A) No commission or other remuneration is paid or given directly or indirectly for soliciting any prospective subscriber;

(B) The number of subscribers does not exceed 10; and

(C) No payment is made by a subscriber;

(15) A transaction pursuant to an offer to existing security holders of the issuer, including persons who at the time of the transaction are holders of convertible securities, nontransferable warrants, or transferable warrants exercisable within not more than 90 days of their issuance, if no commission or other remuneration, other than a standby commission, is paid or given directly or indirectly for soliciting a security holder in the District except to a licensed or exempt broker-dealer;

(16) A transaction involving an offer to sell, but not a sale, of a security if:

(A) A registration statement or offering statement or similar document as required under the Securities Act of 1933 has been filed with the Securities and Exchange Commission, but is not effective;

(B) A registration statement, if required, has been filed under § 31-5603.02, but is not effective; and

(C) No stop order of which the offeror is aware has been entered by the Commissioner or the Securities and Exchange Commission;

(17) The issuance of a security dividend, whether the corporation distributing the dividend is the issuer of the security or not, if nothing of value is given by security holders for the distribution other than the surrender of a right to a cash dividend where the security holder can elect to take a dividend in cash or in a security;

(18) A transaction involving an offer to sell, but not a sale, of a security if:

(A) A registration statement has been filed under § 31-5603.04, but is not effective; and

(B) No stop order of which the offeror is aware has been entered by the Commissioner or the Securities and Exchange Commission;

(19) A transaction incident to a right of conversion or a statutory or judicially approved reclassification, recapitalization, reorganization, quasi-reorganization, stock split, reverse stock split, merger, triangular merger, consolidation, sale of assets, or exchange of securities; and

(20) An offer or sale of units of fractional undivided interests in a unit investment trust registered under the Investment Company Act of 1940 if:

(A) The units have been the subject of a previously effective registration statement under this chapter or were exempt from registration;

(B) The units are offered or sold by a broker-dealer licensed under this chapter; and

(C) The broker-dealer is a sponsor or depositor of the unit investment trust or is an affiliate of the sponsor or depositor.

(Oct. 26, 2000, D.C. Law 13-203, § 402, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(j), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in par. (11), substituted “financial institution” for “financial”; added par. (11A); and in par. (12)(A), substituted “subparagraph (B) of this paragraph” for “paragraph (2) of this subsection”.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5604.03. Additional exemptions.

The Commissioner may, by rule or order, exempt any other security or transaction or class of securities or transactions from § 31-5603.01, § 31-5603.07, or § 31-5604.05. The Commissioner may, by rule or order, adopt a limited offering transactional exemption that will further the objectives of compatibility with the exemptions from securities registration under the Securities Act of 1933 and uniformity among the states.

(Oct. 26, 2000, D.C. Law 13-203, § 403, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5604.04. Revocation of exemptions.

(a) The Commissioner may, by order, deny or revoke an exemption specified in § 31-5604.01(7), (8), (10) or (12) or in § 31-5604.02 for any security or transaction.

(b) An order issued under this section shall not be retroactive. A person shall not violate § 31-5603.01, § 31-5603.07, or § 31-5604.05 by reason of an offer to sell or sale effected after the entry of an order under this section if the person did not know and, in the exercise of reasonable care could not have known, of the order.

(Oct. 26, 2000, D.C. Law 13-203, § 404, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5604.05. Filing of sales and advertising literature.

The Commissioner may, by rule or order, require the filing of a prospectus, pamphlet, circular, form letter, advertisement, or other sales literature or advertising communication, whether communicated in printed form, by electronic means, or otherwise, addressed or intended for distribution to prospective investors, including clients or prospective clients of an investment adviser, unless the security or transaction is exempt under § 31-5604.01 or § 31-5604.02, the security is a federal covered security, the transaction concerns a federal covered security or a federal covered adviser, or the transaction concerns a broker-dealer registered under the Securities Exchange Act of 1934.

(Oct. 26, 2000, D.C. Law 13-203, § 405, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5604.06. Coordination of exemptions.

(a) In furtherance of the policy stated in § 31-5601.02(b), the exemptions under §§ 31-5604.01, 31-5604.02, and 31-5604.03 shall be coordinated with exemptions for securities and transactions under the Securities Act of 1933 so that an offering registered under the Securities Act of 1933 shall be subject to registration by filing under this chapter in the absence of an exemption under this chapter, and an offering exempt from registration under the Securities Act of 1933, other than under the exemption for intrastate offerings, shall be exempt from registration under this chapter.

(b) The Commissioner may make, amend, and rescind rules and regulations for exemptions under §§ 31-5604.01 and 31-5604.02, or added by the Commissioner under § 31-5604.03, but not contained in the Securities Act of 1933 or any of the rules and regulations promulgated thereunder.

(Oct. 26, 2000, D.C. Law 13-203, § 406, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Subchapter V. Fraudulent and Other Prohibited Practices.

§ 31-5605.01. Unlicensed or unregistered activity.

A person shall not:

- (1) Offer or sell a security except in accordance with this chapter;
- (2) Deliver to a purchaser a security required to be registered under § 31-5603.01 unless accompanied or preceded by a registration statement that meets the requirements of § 31-5603.02(b), § 31-5603.03(b), or § 31-5603.04(b);
- (3) Act as a broker-dealer, agent, investment adviser, or investment adviser representative unless licensed as required under § 31-5602.01 or § 31-5602.02; or
- (4) Fail to file with the Commissioner an application, report, or document required to be filed under this chapter, or any rule or regulation adopted by the Commissioner under this chapter, or to fail to comply with the terms of an order issued by the Commissioner issued under this chapter.

(Oct. 26, 2000, D.C. Law 13-203, § 501, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5605.02. Fraudulent transactions.

(a) A person shall not:

- (1) In connection with the rendering of investment advice or in connection with the offer, sale, or purchase of an investment or security, including a security exempt under § 31-5604.01 sold in a transaction exempt under § 31-5604.02, directly or indirectly:
 - (A) Employ a device, scheme, or artifice to defraud;
 - (B) Obtain money or property by means of an untrue statement of a material fact or an omission to state a material fact in order to make the statements made, in the light of the circumstances under which they are made, not misleading; or
 - (C) Engage in a transaction, practice, or course of business which operates, or would operate, as a fraud or deceit upon a person;
- (2) Except as provided in subsection (b) of this section, publish, give publicity to, or circulate a notice, circular, advertisement, newspaper, article, letter, investment service, communication, or broadcast which, though not purporting to offer a security for sale, describes the security for a consideration received or to be received directly or indirectly from an issuer, underwriter, or dealer, or an agent or employee of an issuer, underwriter, or dealer, without fully disclosing the receipt, whether past or prospective, of the consideration and the amount of the consideration;
- (3) In a matter within the jurisdiction of the Commissioner, falsify, conceal, or cover up, by a trick, scheme, or device, a material fact, make any

false, fictitious, or fraudulent statement or representation, or make or use any false writing or document, knowing the same to contain a false, fictitious, or fraudulent statement or entry; or

(4) Except as provided in subsections (b) and (h) of this section, when acting as principal for the person's own account, knowingly sell a security to, or purchase a security from, a client, or acting as broker for a person other than the client, or knowingly effect a sale or purchase of a security for the account of the client, without disclosing to the client in writing before the completion of such transaction the capacity in which the person is acting and obtaining the consent of the client to the transaction.

(b) The prohibition of subsection (a)(2) of this section shall not apply to any information published or circulated relating to a federal covered security. The prohibition of subsection (a)(4) of this section shall not apply to a transaction with a federal covered adviser or to a transaction with a customer of a broker-dealer if the broker-dealer is not acting as an investment adviser in relation to the transaction.

(c) For purposes of this section, the term "investment" means a commitment of money or property principally induced by a representation that an economic benefit may be derived from the commitment; provided, that the term "investment" shall not include a commitment of money or property for:

(1) The purchase of a business opportunity, a business enterprise, or real property; or

(2) The purchase of tangible personal property through a person not engaged in telephone solicitation if there are no specific representations or guarantees made by the offeror or seller as to the economic benefit to be derived from the purchase.

(d) In the solicitation of, or dealings with, advisory clients, a person shall not knowingly make an untrue statement of a material fact, or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which they are made, not misleading.

(e) Except as may be permitted by rule or order of the Commissioner, an investment adviser shall not enter into, extend, or renew an investment advisory contract unless it provides in writing that:

(1) Except as provided in subsections (f)(1) and (h) of this section, the investment adviser shall not be compensated on the basis of a share of capital gains upon, or capital appreciation of, the funds or a portion of the funds of the client;

(2) Except as provided in subsection (h) of this section, no assignment of the contract may be made by the investment adviser without the consent of the other party to the contract; and

(3) Except as provided in subsection (h) of this section, the investment adviser, if a partnership, shall notify the other party to the contract of a change in the membership of the partnership within a reasonable time after the change.

(f)(1) The requirement of subsection (e)(1) of this section shall not prohibit an investment advisory contract which provides for compensation based upon the total value of a fund averaged over a definite period, as of definite dates, or taken as of a definite date.

(2) The term “assignment,” as used in subsection (e)(2) of this section, includes any direct or indirect transfer or pledge without delivery or possession of an investment advisory contract by the assignor or of a controlling block of the assignor’s outstanding voting securities by a security holder of the assignor; provided, that if the investment adviser is a partnership, no assignment of an investment advisory contract shall be considered to result from the death or withdrawal of a minority of the members of the investment adviser having only a minority interest in the business of the investment adviser or from the admission to the investment adviser of one or more members who, after admission, will constitute a minority of the members and will own a minority interest in the business.

(g) An investment adviser shall not take or have custody of any securities or funds of a client if:

(1) The Commissioner, by rule, prohibits custody; or

(2) In the absence of rule, the investment adviser fails to notify the Commissioner that he or she has custody.

(h) The Commissioner may, by rule or order, adopt exemptions from subsections (a)(4), (e)(1), (e)(2), and (e)(3) of this section if the exemptions are consistent with the public interest and within the purposes fairly intended by the policy and provisions of this chapter.

(Oct. 26, 2000, D.C. Law 13-203, § 502, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5605.03. Manipulation of market.

(a) A person shall not, directly or indirectly, in the District:

(1) Quote a fictitious price for a security;

(2) Effect a transaction in a security which involves no change in the beneficial ownership of the security for the purpose of creating a false or misleading appearance of active trading in a security or for the market for the security;

(3) Enter an order for the purchase of a security with the knowledge that an order of substantially the same size and at substantially the same time and price for the sale of the security has been, or will be, entered by or for the same, or an affiliated, person for the purpose of creating a false or misleading appearance of active trading in a security or with respect to the market for the security;

(4) Enter an order for the sale of a security with knowledge that an order of substantially the same size and at substantially the same time and price for the purchase of the security has been or will be entered by or for the same or different parties for the purpose of creating a false or misleading appearance of active trading in a security or with respect to the market for the security; or

(5) Employ any other deceptive or fraudulent device, scheme, or artifice to manipulate the market in a security.

(b) A transaction effected in compliance with, or conduct that does not violate, the applicable provisions of the Securities Exchange Act of 1934, and

the rules and regulations promulgated thereunder, shall not constitute a violation of subsection (a) of this section.

(Oct. 26, 2000, D.C. Law 13-203, § 503, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5605.04. Misleading filings.

A person shall not make, or cause to be made, in a document filed with the Commissioner or in any proceeding under this chapter, a statement which is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.

(Oct. 26, 2000, D.C. Law 13-203, § 504, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5605.05. Unlawful representations concerning licensing, registration, notice filing, or exemption.

(a) The filing of an application for a registration or notice filing under subchapter II, the filing of a registration statement or notice filing under subchapter III, or registration of a person or security shall not constitute a finding by the Commissioner that any document filed under this chapter is true, complete, and not misleading. Such filings, licensure, or registration, or that an exemption or exception is available for a security or a transaction, shall not mean the Commissioner has passed upon the merits or qualifications of, or recommended or given approval to, a person, security, or transaction.

(b) A person shall not make, or cause to be made, to a prospective purchaser, customer, or client a representation inconsistent with subsection (a) of this section.

(Oct. 26, 2000, D.C. Law 13-203, § 505, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

CASE NOTES

ANALYSIS

In General.
Pleadings.

In General.

Pension funds' complaint under District of Columbia statute prohibiting fraud and misrepresentation in securities offering was subject to heightened pleading requirements applicable to averments of fraud. *Hite v. Leeds Weld*

Equity Ptnrs,IV, LP, 429 F.Supp.2d 110, 2006 U.S. Dist. LEXIS 20794 (2006).

Pleadings.

Pension funds' complaint, which alleged that partnership and related entities failed to disclose their relationship with and payment to person associated with investment consulting firm, alleged that omission was made by such defendants as opposed to specific individuals, failed to identify dates of particular meetings

when offers to sell were made, and failed to specify nature of damages, did not plead fraud with sufficient particularity, and thus failed to state cause of action under District of Columbia

statute prohibiting fraud and misrepresentation in securities offering. *Hite v. Leeds Weld Equity Ptnrs, IV, LP*, 429 F.Supp.2d 110, 2006 U.S. Dist. LEXIS 20794 (2006).

Subchapter VI. Enforcement, Criminal, and Civil Liability.

§ 31-5606.01. Investigation; subpoena power.

(a) The Commissioner may:

(1) Make public or private investigations inside or outside of the District as he considers necessary to determine whether a person has violated, or is about to violate, any provision of this chapter, or any rule or order hereunder, to aid in the enforcement of this chapter, or to aid in the prescribing of rules and forms to implement this chapter. The Commissioner may require the person to pay the reasonable costs and expenses of the investigation;

(2) Require or permit the person to file a statement in writing, under oath or otherwise as the Commissioner determines, as to all the facts and circumstances concerning the matter to be investigated; and

(3) Publish information concerning a violation of this chapter or any rule or order adopted under this chapter.

(b) For purposes of an investigation or proceeding under this chapter, the Commissioner may administer oaths and affirmations, subpoena witnesses and compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the Commissioner deems relevant or material to the inquiry.

(c) In case of contumacy by, or refusal to obey a subpoena issued to, a person, the Superior Court of the District of Columbia, upon application by the Commissioner, may issue to the person an order requiring the person to appear before the Commissioner to produce documentary evidence, or to give evidence touching the matter under investigation or in question. Failure to obey the order of the court may be punished as a contempt of court.

(d) No person shall be excused from attending and testifying or from producing a document or record before the Commissioner, in obedience to the subpoena of the Commissioner, or in any proceeding instituted by the Commissioner, on the ground that the testimony or evidence, documentary or otherwise, required of the person may tend to incriminate the person or subject the person to a penalty or forfeiture; provided, that no individual may be prosecuted or subjected to a penalty or forfeiture for or on account of a specific subject concerning which the individual is compelled, after claiming his privilege against self-incrimination as to the specific subject, to testify or produce evidence, documentary or otherwise; provided further, that the individual testifying shall not be exempt from prosecution and punishment for perjury or contempt committed in testifying.

(e) The Commissioner may issue and apply to enforce subpoenas in the District at the request of a securities agency or administrator of another state if the activities constituting an alleged violation for which the information is sought would violate this chapter if the activities had occurred in the District.

(Oct. 26, 2000, D.C. Law 13-203, § 601, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5606.02. Enforcement — Administrative.

(a) Whenever the Commissioner determines that a person has engaged, or is about to engage, in an act or practice constituting a violation of any provision of this chapter or any rule or order hereunder, and that immediate action against such person is in the public interest, the Commissioner may issue, without a hearing, a summary order directing the person to cease and desist from engaging in such activity; provided, that the summary cease and desist order shall give the person:

(1) Notice of the opportunity for a hearing before the Commissioner to determine whether the summary cease and desist order should be vacated, modified, or entered as final; and

(2) Notice that the summary cease and desist order will be entered as final if the person does not request a hearing within 15 days of the receipt of the summary cease and desist order.

(b) Whenever the Commissioner determines after notice and a hearing, unless the right to a hearing is waived, that a person has engaged in an act or practice constituting a violation of this chapter or any rule or order adopted under this chapter, the Commissioner may, in addition to taking any other action authorized under this chapter:

(1) Issue a cease and desist order against the person;

(2) Censure the person if the person is licensed under this chapter;

(3) Bar the person from engaging in the securities business or investment advisory business in the District;

(4) Issue an order against the person imposing a civil penalty up to \$10,000 for any single violation of this chapter; or

(5) Issue an order requiring the person to pay restitution and reasonable costs of the hearing.

(Oct. 26, 2000, D.C. Law 13-203, § 602, 47 DCR 7837; June 25, 2002, D.C. Law 14-150, § 2(k), 49 DCR 4238.)

Effect of amendments. — D.C. Law 14-150, in subsec. (b), deleted “, or his or her designee,” following “Whenever the Commissioner”.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5606.03. Enforcement — Judicial.

(a) Whenever it appears to the Commissioner that a person is about to engage in any act or practice constituting a violation of any provision of this chapter or any rule or order adopted under this chapter, the Commissioner may request the Corporation Counsel to bring an action in the Superior Court of the District of Columbia to obtain one or more of the following remedies:

(1) Temporary restraining order; or

(2) Temporary or permanent injunction.

(b) Whenever it appears to the Commissioner that a person has engaged in any act or practice constituting a violation of any provision of this chapter or any rule or order hereunder, the Commissioner may request the Corporation Counsel to bring an action in the Superior Court of the District of Columbia to obtain one or more of the following remedies:

(1) Temporary restraining order;

(2) Temporary or permanent injunction;

(3) A civil penalty not to exceed \$10,000 for a single violation;

(4) A declaratory judgment;

(5) Appointment of a receiver or conservator for the defendant or the defendant's assets;

(6) A freeze of the defendant's assets; or

(7) Any other relief as the court deems just, such as rescission, restitution, or disgorgement.

(c) The court shall not require the Commissioner to post a bond in any action under this section.

(Oct. 26, 2000, D.C. Law 13-203, § 603, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5606.04. Criminal penalties.

(a) Any person who violates § 31-5605.01 shall be guilty of a misdemeanor and, upon conviction thereof, shall pay a fine of not more than \$1,000, be imprisoned for not more than one year, or both. All prosecutions under this subsection shall be upon information filed in the Superior Court of the District of Columbia in the name of the District by the Corporation Counsel or any of his or her assistants.

(b) Any person who knowingly or intentionally violates any of the provisions of § 31-5605.02, § 31-5605.03, § 31-5605.04, or § 31-5605.05(b), shall be guilty of fraud in the second degree, as defined in § 22-3221(b).

(c) Any person who knowingly or intentionally violates any of the provisions of § 31-5605.02, § 31-5605.03, § 31-5605.04, or § 31-5605.05(b), by use of a plan, program, or campaign that is conducted using one or more telephones or other electronic means of communication for the purpose of inducing the purchase or sale of securities, shall be guilty of fraud in the first degree, as defined in § 22-3221(a).

(d) No prosecution for a violation of this chapter shall bar, or be barred by, a prosecution for the violation of any other law. All prosecutions under this chapter, or based upon any provision of this chapter, shall be commenced within 3 years after the violation upon which the prosecution is based. If the accused person has intentionally concealed evidence of a violation of § 31-5605.02, § 31-5605.03, § 31-5605.04, or § 31-5605.05(b), the period of limitation prescribed in this subsection shall be extended up to an additional 2 years after the prosecuting officer becomes aware of the offense.

(e) Nothing in this chapter shall limit the power of the District to punish a person for conduct constituting a crime under other law.

(Oct. 26, 2000, D.C. Law 13-203, § 604, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5606.05. Civil liability.

(a)(1) A person shall be civilly liable to another person who buys a security if the person:

(A) Offers or sells a security in violation of § 31-5602.01, § 31-5603.01, or § 31-5605.05, of a rule or order under § 31-5604.05 which requires the affirmative approval of sales literature, or of a condition imposed under § 31-5603.05(g) or (h); or

(B) Offers or sells a security by means of an untrue statement of a material fact or an omission to state a material fact necessary in order to make the statement made, in the light of the circumstances under which made, not misleading, the buyer does not know of the untruth or omission and the offeror or seller does not sustain the burden of proof that the offeror or seller did not know, and in the exercise of reasonable care could not have known, of the untruth or omission.

(2) A person shall be civilly liable to another person who sells a security if the person offers to purchase or purchases the security by means of any untrue statement of a material fact or any omission to state a material fact necessary in order to make the statement made, in the light of the circumstances under which it is made, not misleading, the seller does not know of the untruth or omission, and the purchaser does not sustain the burden of proof that the purchaser did not know, and in the exercise of reasonable care could not have known, of the untruth or omission.

(3) A person shall be civilly liable to another person if the person:

(A) Acts as an investment adviser or representative in violation of §§ 31-5602.02, 31-5605.02, 31-5605.05(b), or of any rule or order adopted under § 31-5604.05; or

(B)(i) Receives directly or indirectly any consideration from the other person for advice as to the value of securities or their purchase or sale or for acting as an investment adviser or representative under § 31-5601.01(17) or (18), whether through the issuance of analyses, reports or otherwise, and

(ii) Employs an device, scheme, or artifice to defraud the other person or engages in an act, practice, or course of business which operates or would operate as a fraud or deceit on the other person.

(b)(1) In an action brought under subsection (a)(1) of this section, a buyer may sue at law or in equity:

(A) To recover the consideration paid for the security, interest at the rate used in the Superior Court of the District of Columbia from the date of payment, costs, and reasonable attorneys' fees, less the amount of any income received on the security, upon the tender of the security and any income received on it; or

(B) For damages if the buyer no longer owns the security. The amount of damages shall be the amount that would be recoverable on a tender less the value of the security when the buyer disposed of it, plus interest at the rate used in the Superior Court of the District of Columbia from the date of disposition.

(2) In an action under subsection (a)(2) of this section, a seller may sue at law or in equity:

(A) On tender of the consideration paid for the security, to recover the security, the amount of any income received on the security, costs, and reasonable attorneys' fees; or

(B) For damages if the buyer no longer owns the security.

(3) In an action brought under subsection (a)(3) of this section, a person may sue at law or in equity for the rescission of the advisory contract and any damages resulting from the violation, interest at the rate used in the Superior Court of the District of Columbia from the date of payment of the consideration plus costs and reasonable attorney's fees, less the amount of any income received from such advice.

(c) A person who directly or indirectly controls a person liable under subsection (a) of this section; a partner, officer, or director of the person liable; a person occupying a similar status or performing similar functions; an employee of the person liable who materially aids in the conduct giving rise to the liability; and a broker-dealer or agent who materially aids in the conduct shall be liable jointly and severally with, and to the same extent as the person liable, unless her or she is able to sustain the burden of proof that he or she did not know, and in exercise of reasonable care could not have known, of the existence of the facts by reason of which the liability is alleged to exist. There shall be contribution among the several persons so liable.

(d) A tender specified in this section may be made at any time before entry of judgment.

(e) A cause of action under this chapter shall survive the death of any person who might have been a plaintiff or defendant.

(f)(1) A person may not sue under subsection (a)(1) and (2) of this section after the earlier of 3 years after the contract of sale or purchase, or the time specified in paragraph (2) of this subsection.

(2) An action may not be maintained:

(A) To enforce any liability under subsection (a)(1)(A) of this section unless brought within one year after the violation on which it is based; or

(B) To enforce a liability under subsections (a)(1)(B) or (a)(2) of this section unless brought within one year after the discovery of the untrue statement or omission or after the discovery should have been made by the exercise of reasonable diligence.

(3) A person may not sue under subsection (a)(3) of this section after the earlier of 3 years after the date of the advisory contract or the rendering of investment advice, or the expiration of 2 years after the discovery of the facts constituting the violation.

(g) No person may sue under this section if:

(1) The buyer received a written offer, before suit and at a time when the buyer owned the security or asset, to refund the consideration paid, and

interest at the rate used in the Superior Court of the District of Columbia from the date of payment, less the amount of any income received on the security or asset, and the buyer failed to accept the offer within 30 days of its receipt;

(2) The buyer received such an offer before suit and at a time when the buyer did not own the security or asset, unless the buyer rejected the offer in writing within 30 days of its receipt; or

(3) The seller received a written offer from the buyer, before suit, to return the security or asset, together with the amount of any income received on the security, and interest at the rate used by the Superior Court of the District of Columbia from the date of payment, and the seller failed to accept the offer within 30 days of its receipt.

(h) No person may sue on a contract if the person has made or engaged in the performance of the contract in violation of this chapter or any rule or order adopted under this chapter, or has acquired any purported right under the contract with knowledge of the facts by reason of which its making or performance violated this chapter or a rule or order adopted under this chapter.

(i) A condition, stipulation, or provision that binds a person who acquires a security or asset, or receives a investment advice, to waive compliance with a provision of this chapter or a rule or order adopted under this chapter shall be void.

(j) The rights and remedies provided by this chapter shall be in addition to any other rights or remedies that may exist at law or in equity, but this chapter does not create a cause of action not specified in this section or authorized under the bonding requirements of § 31-5602.03(h).

(Oct. 26, 2000, D.C. Law 13-203, § 605, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

CASE NOTES

ANALYSIS

In General.
Pleadings.

In General.

Pension funds' complaint under District of Columbia statute prohibiting fraud and misrepresentation in securities offering was subject to heightened pleading requirements applicable to averments of fraud. *Hite v. Leeds Weld Equity Ptnrs,IV, LP*, 429 F.Supp.2d 110, 2006 U.S. Dist. LEXIS 20794 (2006).

Pleadings.

Pension funds' complaint, which alleged that

partnership and related entities failed to disclose their relationship with and payment to person associated with investment consulting firm, alleged that omission was made by such defendants as opposed to specific individuals, failed to identify dates of particular meetings when offers to sell were made, and failed to specify nature of damages, did not plead fraud with sufficient particularity, and thus failed to state cause of action under District of Columbia statute prohibiting fraud and misrepresentation in securities offering. *Hite v. Leeds Weld Equity Ptnrs,IV, LP*, 429 F.Supp.2d 110, 2006 U.S. Dist. LEXIS 20794 (2006).

*Subchapter VII. Administration.***§ 31-5607.01. Administration of chapter.**

This chapter shall be administered by the Commissioner.

(Oct. 26, 2000, D.C. Law 13-203, § 701, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.02. Prohibitions on use of information.

The Commissioner or an employee of the Commissioner shall not use for personal gain or benefit information filed with or obtained by the Commissioner which is not public information. The Commissioner or an employee of the Commissioner shall not conduct securities dealings based upon information filed with or obtained by the Commissioner, even though public, if there has not been sufficient time for the securities markets to assimilate the information.

(Oct. 26, 2000, D.C. Law 13-203, § 702, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.03. Public information; confidentiality.

(a) Except as provided in subsection (b) of this section, information and documents filed with, or obtained by, the Commissioner shall be available for public examination under subchapter II of Chapter 5 of Title 2.

(b) The following information and documents shall not constitute public information under subsection (a) of this section:

(1) Information or documents obtained by the Commissioner in connection with an investigation under § 31-5606.01; and

(2) Information or documents filed with the Commissioner in connection with a registration statement under subchapter III of this chapter or a report under § 31-5602.04 constituting trade secrets or commercial or financial information of a person for which a person is entitled to a claim of confidentiality or privilege.

(Oct. 26, 2000, D.C. Law 13-203, § 703, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.04. Cooperation with other agencies.

(a) To encourage uniform interpretation and administration of this chapter and effective securities regulation and enforcement, the Commissioner may cooperate with the securities agencies or administrators of one or more states, Canadian provinces or territories, or another country, the Securities and

Exchange Commission, the Commodity Futures Trading Commission, the Securities Investor Protection Corporation, any self-regulatory organization, any national or international organization of securities officials or agencies, and any governmental law enforcement or regulatory agency.

(b) The cooperation authorized by subsection (a) shall include the following actions:

- (1) Establishing a central depository for registration under this chapter and for documents or records required or allowed to be maintained under this chapter;
- (2) Making a joint registration examination or investigation;
- (3) Holding a joint administrative hearing;
- (4) Filing and prosecuting a joint civil or administrative proceeding;
- (5) Sharing and exchanging personnel;
- (6) Sharing and exchanging information and documents; and
- (7) Formulating rules or proposed rules, statements of policy, guidelines, and interpretative opinions and releases.

(Oct. 26, 2000, D.C. Law 13-203, § 704, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.05. Rules, forms, and orders.

(a) In addition to specific authority otherwise granted by this chapter, the Commissioner:

(1) Shall adopt, as a rule, a description of the general course and method of where and how a person may obtain information or make a submission or request;

(2) Shall adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available to a person, including all forms that are to be used by a person dealing with the Commissioner;

(b) To keep rules adopted by the Commissioner in harmony with the regulations adopted by the Securities and Exchange Commission under the federal securities laws and to encourage uniformity with the rules of securities agencies and administrators in other states, the Commissioner, so far as is consistent with this chapter, shall take into consideration the regulations adopted by the Securities and Exchange Commission and the rules of securities agencies and administrators in other states which have enacted a law comparable to this chapter.

(c) Unless specifically provided in this chapter to the contrary, a rule or order may not be adopted, amended, or repealed unless the Commissioner determines that the action is in the public interest and appropriate for the protection of investors and is consistent with the purposes fairly intended by the policy and provisions of this chapter.

(d) The Commissioner may, by rule or order, prescribe the form and content of financial statements required under this chapter, the circumstances under which consolidated financial statements must be filed, and whether a required financial statement must be certified and by whom. Unless the Commissioner

provides, by rule or order, otherwise, and subject to the limitations of section 15 of the Securities Exchange Act of 1934 [15 U.S.C. § 78o] and section 222 of the Investment Advisers Act of 1940 [15 U.S.C. § 80b-18a], a financial statement required under this chapter must be prepared in accordance with generally accepted accounting principles or other accounting principles as are prescribed for the issuer of the financial statement by the Securities and Exchange Commission.

(Oct. 26, 2000, D.C. Law 13-203, § 705, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.06. Consent to service of process.

(a) An applicant for licensure or registration under this chapter, and every issuer that proposes to offer a security in the District through any person acting as an agent, shall file with the Commissioner, in such form as may be prescribed by rule, an irrevocable consent appointing the Commissioner to be the person's attorney to receive service of any lawful process in any non-criminal suit, action, or proceeding against the person or the person's successor, executor or administrator which arises under this chapter, or any rule or order hereunder, after the consent is filed, with the same force and validity as if served personally on the person filing the consent.

(b) A person who has filed a consent complying with subsection (a) of this section in connection with a previous application for licensing, registration, or notice filing need not file an additional consent.

(c) If any person, including a nonresident of the District, engages in conduct prohibited or made actionable by this chapter or a rule or order hereunder, and the person has not filed a consent to service of process under subsection (a) of this section, and personal jurisdiction over the person cannot otherwise be obtained in the District, the conduct shall be deemed the person's appointment of the Commissioner to be the person's attorney to receive service of any lawful process in any non-criminal suit, action, or proceeding against the person or the person's successor, executor or administrator, which grows out of the conduct and which is brought under this chapter, or a rule or order adopted under this chapter, with the same force and validity as if served on the person personally.

(d) Service under subsection (a) or (c) of this section may be made by leaving a copy of the process in the Commissioner's office, but it shall not be effective unless:

(1) The plaintiff, who may be the Commissioner in a suit, action, or proceeding instituted by the Commissioner, sends notice of the service and a copy of the process by registered or certified mail to the defendant or respondent at that person's last address on file with the Commissioner, or takes other steps reasonably calculated to give actual notice; and

(2) The plaintiff's affidavit of compliance with this subsection is filed on or before the return day of the process, if any, or within such further time as the court or the Commissioner, in a proceeding before the Commissioner, allows.

(e) Service as provided in subsection (d) of this section may be utilized in a proceeding before the Commissioner or by the Commissioner in a proceeding in which the Commissioner is the moving party.

(f) When process is served under this section, the court, or the Commissioner, in a proceeding before the Commissioner, shall order such continuance as may be necessary to afford the defendant or respondent reasonable opportunity to defend.

(Oct. 26, 2000, D.C. Law 13-203, § 706, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.07. Administrative files and records.

(a) The Commissioner shall keep one or more registers of all applications for licensing and registration under this chapter, all notice filings, licenses and registration statements that become effective under this chapter, all disciplinary and enforcement orders issued and reports of investigation made under this chapter, all declaratory orders and rulings issued under this chapter, and all other orders issued under this chapter.

(b) The Commissioner shall retain:

(1) All licenses and related applications and all registration statements and notice filings currently effective or that have been effective within the last 5 years;

(2) All licenses and related applications and all registration statements that have been denied, suspended, or revoked within the last 5 years and the order of suspension, denial, or revocation;

(3) All investigatory files under this chapter that are open or that have been closed within the last 5 years and any disciplinary or closure orders pertaining to the files;

(4) The transcript or record of all administrative hearings held during the last 5 years; and

(5) All other orders of the Commissioner entered under this chapter.

(c) All records required to be maintained pursuant to subsections (a) and (b) of this section may be maintained in any form of data storage. Upon request, the Commissioner shall certify under the seal of the Department a copy as being a true and correct copy of the records maintained by the Department. The Commissioner may, by rule, establish reasonable charges for furnishing or certifying copies. In an investigation or proceeding, a copy so certified shall be prima facie evidence of the contents of the records certified.

(Oct. 26, 2000, D.C. Law 13-203, § 707, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.08. Provisions applicable to administrative proceedings.

(a) All actions of the Commissioner, including administrative proceedings, adoption of rules, and issuance of orders shall be governed by subchapter I of Chapter 5 of Title 2; provided, that:

(1) The issuance of a stop order under § 31-5603.03(e) shall be governed by § 31-5603.03(e); and

(2) The issuance of a summary order under § 31-5606.02(a) shall be governed by § 31-5606.02(a).

(Oct. 26, 2000, D.C. Law 13-203, § 708, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5607.09. Electronic filings.

(a) The Commissioner may, by rule or order, prescribe acceptable methods for filing applications, forms, notices, prospectuses, registration statements, or other documents with the Department in electronic form.

(b) The Commissioner may, by rule or order, prescribe acceptable methods for executing electronic signatures or otherwise for documents filed with the Department in electronic form.

(c) An electronic signature used in connection with an electronic filing shall have the same legal effect as a manual signature.

(Oct. 26, 2000, D.C. Law 13-203, § 709, as added June 25, 2002, D.C. Law 14-150, § 2(l), 49 DCR 4238.)

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

Subchapter VIII. Miscellaneous Provisions.

§ 31-5608.01. Scope of Chapter.

(a) Sections 31-5602.01, 31-5603.01, 31-5605.01, or 31-5605.02, 31-5605.05, and 31-5606.05 shall apply to a person who sells, or offers to sell, when an offer to sell is made in the District or an offer to purchase is made and accepted in the District.

(b) Sections 31-5602.01, 31-5605.01, or 31-5605.02, and 31-5605.05 shall apply to a person who purchases, or offers to purchase, when an offer to purchase, is made in the District or an offer to sell is made and accepted in the District.

(c) For the purpose of this section, an offer to sell or to purchase is made in the District, whether or not either person is present in the District, if the offer originates in the District, or is directed by the offeror to a destination in the District and received where it is directed or at a post office in the District if the offer is mailed.

(d) For the purpose of this section, an offer to purchase or to sell is accepted in the District if the acceptance is communicated to the offeror in the District and has not previously been communicated to the offeror, orally or in writing, outside the District. The acceptance is communicated to the offeror in the District, whether or not either party is then present in the District, when the offeree directs it to the offeror in the District reasonably believing the offeror to be in the District and it is received at the place to which it is directed or at any post office in the District in the case of a mailed acceptance.

(e) An offer to sell or purchase is not made in the District when the publisher circulates, or there is circulated on the publisher's behalf, in the District a bona fide newspaper or other publication of general, regular, and paid circulation which is not published in the District, or which is published in the District, but has had more than $\frac{2}{3}$ of its circulation outside the District during the last 12 months, or a radio or television program originating outside the District is received in the District.

(Oct. 26, 2000, D.C. Law 13-203, § 801, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5608.02. District of Columbia Securities Advisory Committee.

(a) The Mayor shall appoint a District of Columbia Advisory Committee which shall consist of 6 members who shall be residents of the District, Maryland, or Virginia, at least 2 of whom shall be actively engaged in the securities business and at least 2 of whom shall be members of the bar of the District of Columbia.

(b) No more than 3 members of the Advisory Committee shall be members of the same political party. The members shall be selected on the basis of their experience and qualifications to advise the Commissioner on all phases of the securities business.

(c) Members of the Advisory Committee shall be appointed for staggered terms of 3 years each, with 2 members appointed each year, to serve without compensation and eligible for reappointment for additional terms. Of the first members appointed hereunder, 2 shall be appointed for one year, 2 shall be appointed for 2 years, and 2 shall be appointed for 3 years, as designated by the Mayor at the time of their appointment.

(d) The members of the Advisory Committee shall select their own chairperson. Meetings of the Advisory Committee shall be held when called by the Commissioner.

(e) The Advisory Committee shall give the Commissioner the benefit of its advice on any and all matters pertaining to the administration of this chapter, particularly the adoption, amendment of repeal of rules, regulations, and forms.

(Oct. 26, 2000, D.C. Law 13-203, § 802, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

§ 31-5608.03. Judicial review.

(a) If a hearing is conducted under the contested case procedure in accordance with § 2-509, a person suffering a legal wrong, or adversely affected or aggrieved, by an order or decision may appeal to the District of Columbia Court of Appeals in accordance with § 2-510.

(b) The filing of an appeal under this section shall not stay the application of a rule, regulation, order, or other action of the Commissioner to the appealing party unless the court, after giving the appealing party notice and an opportunity to be heard, determines that failure to grant a stay would be detrimental to the interest of policyholders, shareholders, creditors, or the public.

(Oct. 26, 2000, D.C. Law 13-203, § 803, 47 DCR 7837; June 19, 2001, D.C. Law 13-313, § 22, 48 DCR 1873; June 25, 2002, D.C. Law 14-150, § 2(m), 49 DCR 4238.)

Effect of amendments. — D.C. Law 13-313 rewrote subsec. (a) which had read:

“(a) A person aggrieved by an act, determination, rule, regulation, order, or any other action of the Mayor, may appeal to the District of Columbia Court of Appeals in accordance with § 2-510.”

D.C. Law 14-150 substituted “Commissioner” for “Mayor” throughout the section.

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

Legislative history of Law 13-313. — For D.C. Law 13-313, see notes following § 31-4434.

Legislative history of Law 14-150. — For Law 14-150, see notes following § 31-5601.01.

§ 31-5608.04. Repeal and transition provisions.

(a) Chapters 36 and 37 of Title 3 (“prior law”), are repealed, subject to the transition provisions of subsections (b) through (e) of this section.

(b) Prior law shall govern all suits, actions, prosecutions, or proceedings which are pending or may be initiated on the basis of facts or circumstances occurring before October 26, 2000.

(c) A civil suit or action shall not be maintained to enforce a liability under prior law unless brought within the period of limitation which applied when the cause of action accrued and, in any event, no later than 2 years after October 26, 2000.

(d) All effective registrations and notice filings under prior law, all administrative orders relating to such registrations and notice filings, and all conditions imposed upon such registrations shall apply to the extent they would have applied under prior law.

(e) All no-action and opinion letters, administrative orders, and waivers issued under prior law or regulation shall apply to the extent they would have applied under prior law.

(Oct. 26, 2000, D.C. Law 13-203, § 804, 47 DCR 7837.)

Legislative history of Law 13-203. — For Law 13-203, see notes following § 31-5601.01.

SUBTITLE XI. REPEALED PROVISIONS.

CHAPTER 57. FRATERNAL BENEFIT ASSOCIATIONS [REPEALED].

Sec.

31-5701 to 31-5728. [Repealed].

§ 31-5701. Definition; authorized benefits and funds; governing provisions. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1310, ch. 854, § 749; Dec. 20, 1928, 45 Stat. 1055, ch. 40, § 1; 1973 Ed., § 35-901; Mar. 13, 1993, D.C. Law 9-181, § 2, 39 DCR 8081; Mar. 16, 1993, D.C. Law 9-193, § 2, 39 DCR 9009; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1201.

1973 Ed., § 35-901.

Legislative history of Law 9-181. — Law 9-181, the “Fraternal Benefit Association Beneficiaries Designation Temporary Amendment Act of 1992,” was introduced in Council and assigned Bill No. 9-581, which was retained by Council. The Bill was adopted on first and second readings on July 7, 1992, and October 6, 1992, respectively. Signed by the Mayor on October 23, 1992, it was assigned Act No. 9-300 and transmitted to both Houses of Congress for its review. D.C. Law 9-181 became effective on March 13, 1993.

Legislative history of Law 9-193. — Law 9-193, the “Fraternal Benefit Association Beneficiaries Designation Amendment Act of 1992,” was introduced in Council and assigned Bill No. 9-444, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill

was adopted on first and second readings on October 6, 1992, and November 4, 1992, respectively. Signed by the Mayor on November 23, 1992, it was assigned Act No. 9-314 and transmitted to both Houses of Congress for its review. D.C. Law 9-193 became effective on March 16, 1993.

Legislative history of Law 12-86. — Law 12-86, the “Omnibus Regulatory Reform Amendment Act of 1998,” was introduced in Council and assigned Bill No. 12-458, which was referred to the Committee on Public Works and the Environment and the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 19, 1997, and January 6, 1998, respectively. Signed by the Mayor on January 21, 1998, it was assigned Act No. 12-256 and transmitted to both Houses of Congress for its review. D.C. Law 12-86 became effective on April 29, 1998.

§ 31-5702. Authority of existing associations to continue business. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1310, ch. 854, § 750; 1973 Ed., § 35-902; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1202.

1973 Ed., § 35-902.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The

Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective May 21, 1997.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see His-

torical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: The Department of Insurance, including the Superintendent, was abolished and the functions thereof transferred to the Board of Commissioners of the District of Columbia by Reorganization Plan No. 5 of 1952. Reorganization Order No. 43, dated June 23, 1953, as amended, established, under the direction and control of a Commissioner, a Department of Insurance headed by a Superintendent. The Order provided for the organization of the Department, abolished the previously existing Department of Insurance, and provided that all functions and positions of the previous Department would be transferred to the new Department of Insurance, including the duties, powers, and authorities of all officers and employees; and that all personnel, property,

records and unexpended balances relating to the functions and positions transferred would also be transferred to the new Department. The executive functions of the Board of Commissioners were transferred to the Commissioner of the District of Columbia by § 401 of Reorganization Plan No. 3 of 1967. The functions of the Superintendent of Insurance were transferred to the Department of Consumer and Regulatory Affairs by Reorganization Plan No. 1 of 1983, effective March 31, 1983. Pursuant to the provisions of D.C. Law 11-268, the Department of Insurance and Securities Regulation was established and the duties of the Superintendent of Insurance and the Insurance Administration were assumed by the Commissioner of Insurance and Securities and the Insurance Administration in the Department of Consumer and Regulatory Affairs was abolished.

§ 31-5703. Nonresident associations; filing requirements; required showing of authority; examinations. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1310, ch. 854, § 751; 1973 Ed., § 35-903; Mar. 21, 1995, D.C. Law 10-233, § 5, 42 DCR 24; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1203.

1973 Ed., § 35-903.

Legislative history of Law 10-233. — Law 10-233, the "Insurers Service of Process Act of 1994," was introduced in Council and assigned Bill No. 10-666, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on

December 27, 1994, it was assigned Act No. 10-376 and transmitted to both Houses of Congress for its review. D.C. Law 10-233 became effective on March 21, 1995.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5704. Required annual reports; contents. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1311, ch. 854, § 752; 1973 Ed., § 35-904; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1204.

1973 Ed., § 35-904.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see His-

torical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5705. Service of process on nonresident associations. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1312, ch. 854, § 753; 1973 Ed., § 35-905; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1205.

Legislative history of Law 10-128. — Law 10-128, the “Omnibus Budget Support Act of 1994,” was introduced in Council and assigned Bill No. 10-575, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on March 22, 1994, and April 12, 1994, respectively. Signed by the Mayor on April 14, 1994, it was assigned Act No. 10-225 and transmitted to both Houses of Congress for its review. D.C. Law 10-128 became effective on June 14, 1994.

Legislative history of Law 10-233. — For legislative history of D.C. Law 10-233, see Historical and Statutory Notes following § 31-5703.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor’s notes. — Former § 35-1205 1981 Ed. had also been amended by D.C. Law 10-128.

D.C. Law 11-268, § 10(n) (44 DCR 1730), eff. May 21, 1997, amends § 35-1205 1981 Ed. without reference to its prior repeal.

§ 31-5706. Issuance of permit to do business. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1312, ch. 854, § 754; 1973 Ed., § 35-906; June 14, 1994, D.C. Law 10-128, § 402(b), 41DCR 2096; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1206.

1973 Ed., § 35-906.

Legislative history of Law 10-128. — For legislative history of D.C. Law 10-128, see Historical and Statutory Notes following § 31-5705.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Legislative history of Law 12-261. — Law 12-261, the Second Omnibus Regulatory Re-

form Amendment Act of 1998, was introduced in Council and assigned Bill No. 12-845, which was referred to the Committee of the Whole. The Bill was adopted on first and second reading on and respectively. Signed by the Mayor on Dec. 31, 1998, it was assigned Act No. 12-615, and transmitted to both Houses of Congress for review. D.C. Law 12-261 became effective on April 20, 1999.

Editor’s notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

D.C. Law 12-261, title II, § 2003(gg)(2) (46 DCR 3142), eff. April 20, 1999, amended § 35-1206 § 31-5706, 2001 Ed. without reference to its prior repeal.

§ 31-5707. Formation procedure. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1313, ch. 854, § 755; Oct. 5, 1962, 76 Stat. 752, Pub. L.

87-757, § 2; 1973 Ed., § 35-907; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1207. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 351-5701.
1973 Ed., § 35-907.

Legislative history of Law 12-86. — For

§ 31-5708. Reincorporation or continuance of powers of existing corporations. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1313, ch. 854, § 756; 1973 Ed., § 35-908; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1208. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.
1973 Ed., § 35-908.

Legislative history of Law 12-86. — For

§ 31-5709. Incorporation of subordinate bodies. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1314, ch. 854, § 757; 1973 Ed., § 35-909; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1209. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.
1973 Ed., § 35-909.

Legislative history of Law 12-86. — For

§ 31-5710. Payment of assessments and/or dues by beneficiary. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1314, ch. 854, § 758; 1973 Ed., § 35-910; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1210. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.
1973 Ed., § 35-910.

Legislative history of Law 12-86. — For

§ 31-5711. Exemption of benefits from legal process. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1314, ch. 854, § 759; 1973 Ed., § 35-911; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1211.
1973 Ed., § 35-911.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5712. Meetings. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1314, ch. 854, § 760; 1973 Ed., § 35-912; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1212.
1973 Ed., § 35-912.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5713. Fraudulent representations. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1315, ch. 854, § 761; June 30, 1902, 32 Stat. 534, ch. 1329, § 761; 1973 Ed., § 35-913; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1213.
1973 Ed., § 35-913.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5714. Violations of provisions or injunction. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1315, ch. 854, § 762; 1973 Ed., § 35-914; Oct. 5, 1985, D.C. Law 6-42, § 470(g), 32 DCR 4450; May 21, 1997, D.C. Law 11-268, § 10(n), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1214.
1973 Ed., § 35-914.

Legislative history of Law 6-42. — Law 6-42, the "Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985," was introduced in Council and assigned Bill No. 6-187, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 25, 1985, and July 9, 1985, respectively. Signed by the Mayor on July 16, 1985, it was assigned Act No. 6-60 and transmitted to both Houses of Congress for its review.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

Change in Government. — This section originated at a time when local government powers were delegated to a Board of Commissioners of the District of Columbia (see Acts Relating to the Establishment of the District of Columbia and its Various Forms of Governmental Organization in Volume 1). Section 401 of Reorganization Plan No. 3 of 1967 (see Reorganization Plans in Volume 1) transferred all of the functions of the Board of Commissioners under this section to a single Commissioner.

The District of Columbia Self-Government and Governmental Reorganization Act, 87 Stat. 818, § 711 (D.C. Code, § 1-207.11, abolished the District of Columbia Council and the Office of Commissioner of the District of Columbia. These branches of government were replaced

by the Council of the District of Columbia and the Office of Mayor of the District of Columbia, respectively. Accordingly, and also pursuant to § 714(a) of such Act (D.C. Code, § 1-207.14(a)), appropriate changes in terminology were made in this section.

§ 31-5715. Individual violations of provisions. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1315, ch. 854, § 763; 1973 Ed., § 35-915; Oct. 5, 1985, D.C. Law 6-42, § 470(h), 32 DCR 4450; 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1215.

1973 Ed., § 35-915.

Legislative history of Law 6-42. — For legislative history of D.C. Law 6-42, see Historical and Statutory Notes following § 31-5714.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Section 35-1215 § 31-5715, 2001 Ed. was also amended by D.C. Law 12-81 to validate a previously made technical correction.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5716. Exceptions for associations for profit, certain specified organizations. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1316, ch. 854, § 764; Dec. 12, 1928, 45 Stat. 1021, ch. 24; 1973 Ed., § 35-916; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1216.

1973 Ed., § 35-916.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5717. Exceptions to provisions — Associations or individuals using name of previously existing corporation. [Repealed].

Repealed.

(Mar. 3, 1901, 31 Stat. 1316, ch. 854, § 765; 1973 Ed., § 35-917; Apr. 29, 1998, D.C. Law 12-86, § 1237(a), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1217.

1973 Ed., § 35-917.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5718. Insurance and/or annuities upon lives of children; applications. [Repealed].

Repealed.

(May 29, 1928, 45 Stat. 953, ch. 862, § 2; 1973 Ed., § 35-918; Apr. 29, 1998, D.C. Law 12-86, § 1237(b), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1218. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

1973 Ed., § 35-918.

Legislative history of Law 12-86. — For

§ 31-5719. Insurance and/or annuities upon lives of children; applications — Computation of contributions. [Repealed].

Repealed.

(May 29, 1928, 45 Stat. 953, ch. 862, § 3; 1973 Ed., § 35-919; Apr. 29, 1998, D.C. Law 12-86, § 1237(b), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1219. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

1973 Ed., § 35-919.

Legislative history of Law 12-86. — For

§ 31-5720. Insurance and/or annuities upon lives of children; applications — Required reserve. [Repealed].

Repealed.

(May 29, 1928, 45 Stat. 953, ch. 862, § 4; 1973 Ed., § 35-920; Apr. 29, 1998, D.C. Law 12-86, § 1237(b), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1220. legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

1973 Ed., § 35-920.

Legislative history of Law 12-86. — For

§ 31-5721. Insurance and/or annuities upon lives of children; applications — Powers of society. [Repealed].

Repealed.

(May 29, 1928, 45 Stat. 953, ch. 862, § 5; 1973 Ed., § 35-921; Apr. 29, 1998, D.C. Law 12-86, § 1237(b), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1221. 1973 Ed., § 35-921.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5722. Separation of fraternal and insurance activities; corporations affected. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 158, ch. 135, § 1; 1973 Ed., § 35-922; May 21, 1997, D.C. Law 11-268, § 10(o), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1222.

1973 Ed., § 35-922.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5723. Separation of fraternal and insurance activities — Certificate of corporation to be filed; contents. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 158, ch. 135, § 2; 1973 Ed., § 35-923; 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1223.

1973 Ed., § 35-923.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — This section was also amended by D.C. Law 12-81 to validate previously made technical corrections.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5724. Separation of fraternal and insurance activities — Approval and certificates of Commissioner required. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 159, ch. 135, § 3; 1973 Ed., § 35-924; May 21, 1997, D.C. Law 11-268, § 10(o), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1224.

1973 Ed., § 35-924.

Legislative history of Law 11-268. — For

legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5725. Separation of fraternal and insurance activities — General powers, duties, liabilities and structure of activities. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 159, ch. 135, § 4; 1973 Ed., § 35-925; 1997, D.C. Law 11-268, § 10, 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1225.

1973 Ed., § 35-925.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see His-

torical and Statutory Notes following § 31-5701.

Editor's notes. — This section was also amended by D.C. Law 12-81 to validate previously made technical corrections.

Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5726. Separation of fraternal and insurance activities — Continuation and supervision of original corporation. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 160, ch. 135, § 5; 1973 Ed., § 35-926; May 21, 1997, D.C. Law 11-268, § 10(o), 44 DCR 1730; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1226.

1973 Ed., § 35-926.

Legislative history of Law 11-268. — For legislative history of D.C. Law 11-268, see Historical and Statutory Notes following § 31-5702.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

Editor's notes. — Department of Insurance abolished: See Historical and Statutory Notes following § 31-5702.

§ 31-5727. Separation of fraternal and insurance activities — Existing contracts preserved; Congressional powers reserved. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 160, ch. 135, § 6; 1973 Ed., § 35-927; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1227.

1973 Ed., § 35-927.

Legislative history of Law 12-86. — For

legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

§ 31-5728. Separation of fraternal and insurance activities — Applicability of state and District laws. [Repealed].

Repealed.

(Apr. 12, 1930, 46 Stat. 160, ch. 135, § 7; 1973 Ed., § 35-928; Apr. 29, 1998, D.C. Law 12-86, § 1237(c), 45 DCR 1223.)

Prior Codifications. — 1981 Ed., § 35-1228.

1973 Ed., § 35-928.

Legislative history of Law 12-86. — For legislative history of D.C. Law 12-86, see Historical and Statutory Notes following § 31-5701.

CHAPTER 58. HOLDING COMPANY SYSTEM [REPEALED].

Sec.

31-5801 to 31-5815. [Repealed].

§§ 31-5801 to 31-5815. Definitions; subsidiaries of domestic insurers; acquisition of control of or merger with domestic insurer; registration of insurers; transactions by insurers; examination of insurers; confidential treatment of information and documents of insurers; rules; regulations and orders; violations of chapter — Civil remedies; criminal proceedings; takeover of insurer by Mayor; suspension, revocation, or nonrenewal of insurer's license; judicial remedies of persons aggrieved by actions of Mayor; chapter to supersede other laws; separability. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-44, § 17, 40 DCR 6027.)

Prior Codifications. — 1981 Ed., §§ 35-2001 to 35-2015.

Legislative history of Law 10-44. — Law 10-44, the "Holding Company System Act of 1993," was introduced in Council and assigned Bill No. 10-132, which was referred to the Committee on Consumer and Regulatory Af-

fairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 5, 1993, it was assigned Act No. 10-79 and transmitted to both Houses of Congress for its review. D.C. Law 10-44 became effective on October 21, 1993.

CHAPTER 59. INSURANCE AGENTS OTHER THAN LIFE [REPEALED].

Sec.

31-5901, 31-5902. [Repealed.]

§§ 31-5901, 31-5902. Required licenses for agents or brokers; compensation to unlicensed agents prohibited; violations; exemption of fraternal associations from provisions; licenses required for authorized solicitors; assignment of licenses; violations. [Repealed].

Repealed.

(April 9, 1997, D.C. Law 11-227, § 16(b), 44 DCR 140.)

Prior Codifications. — 1981 Ed., §§ 35-1301, 35-1302.

Legislative history of Law 11-227. — Law 11-227, the “Insurance Agents and Brokers Licensing Revision Act of 1996,” was introduced in Council and assigned Bill No. 11-523, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on October 1, 1996, and November 7, 1996, respectively. Signed by the Mayor on December 4, 1996, it was assigned Act No. 11-455 and transmitted to both Houses of Congress for its review. D.C. Law 11-227 became effective on April 9, 1997.

Legislative history of Law 11-268. — Law 11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,”

was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became law on May 21, 1997.

Editor’s notes. — Former § 35-1301 was also amended by § 10(p) of D.C. Law 11-268, became effective on May 21, 1997. The amendment by D.C. Law 11-268, substituted “Commissioner of Insurance and Securities” for “Superintendent of Insurance of the District” in the first sentence.

CHAPTER 60. INSURANCE GUARANTY ASSOCIATION [REPEALED].

Sec.

31-6001 to 31-6017. [Repealed].

§§ 31-6001 to 31-6017. Purposes of chapter; applicability of chapter; definitions; creation; composition; performance of functions; exercise of powers; organization; board of directors; powers and duties of Association; plan of operation; notice of claims against insurers; powers and duties of Mayor; effect of paid claims; nonduplication of recovery; detection and prevention of insolvencies; examination and regulation of Association; exemption from fees and taxes; policy rates and premiums; immunity from liability; proceedings involving insolvent insurers; re-opening default judgments; termination of operations and accounts; expiration of chapter. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-51, § 17, 40 DCR 6120.)

Prior Codifications. — 1981 Ed., §§ 35-1901 to 35-1917.

Legislative history of Law 10-51. — Law 10-51, the “Property and Liability Insurance Guaranty Association Act of 1993,” was introduced in Council and assigned Bill No. 10-134, which was referred to the Committee on Con-

sumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-96 and transmitted to both Houses of Congress for its review. D.C. Law 10-51 became effective on October 21, 1993.

CHAPTER 61. MEDICARE SUPPLEMENT INSURANCE [REPEALED].

Sec.

31-6101 to 31-6109. [Repealed].

§§ 31-6101 to 31-6109. Definitions; applicability of chapter; policy definitions and terms; prohibited policy provisions; notice of free examination; minimum benefit standards; loss ratio standards; required disclosure provisions; requirements for replacement. [Repealed].

Repealed.

(Mar. 8, 1991, D.C. Law 8-244, § 12, 38 DCR 360.)

Prior Codifications. — 1981 Ed., §§ 35-2201 to 35-2209.

Temporary Amendment of Section. — Temporary repeal of chapter: Section 12 of D.C. Law 8-68, effective February 22, 1990, and section 12 of D.C. Law 8-218, effective March 6, 1991, repealed this chapter.

Legislative history of Law 8-244. — Law 8-244, the “Medicare Catastrophic Coverage Repeal Minimum Guidelines Act of 1990,” was

introduced in Council and assigned Bill No. 8-241, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 4, 1990, and December 18, 1990, respectively. Signed by the Mayor on December 27, 1990, it was assigned Act No. 8-327 and transmitted to both Houses of Congress for its review.

CHAPTER 62. REGULATION OF FIRE INSURANCE RATES [REPEALED].

Sec.

31-6201 to 31-6209. [Repealed].

§§ 31-6201 to 31-6209. Definitions; applicability of provisions; adjustment of rates; removal of discriminations; right of aggrieved party to administrative or judicial hearing; Rating Bureau; conformance of policies to requirements of Superintendent; excess rates; records required to be kept; examination of records; required reports; filing requirements; violations. [Repealed].

Repealed.

(Oct. 21, 1993, D.C. Law 10-40, § 13(b), 40 DCR 6009.)

Prior Codifications. — 1981 Ed., §§ 35-1601 to 35-1609.

Legislative history of Law 10-40. — Law 10-40, the “Insurance Regulatory Trust Fund Act of 1993,” was introduced in Council and assigned Bill No. 10-93, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on August 4, 1993, it was assigned Act No. 10-75 and transmitted to both Houses of Congress for its review. D.C. Law 10-40 became effective on October 21, 1993.

Legislative history of Law 11-268. — Law

11-268, the “Department of Insurance and Securities Regulation Establishment Act of 1996,” was introduced in Council and assigned Bill No. 11-415, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on November 7, 1996, and December 3, 1996, respectively. Signed by the Mayor on December 30, 1996, it was assigned Act No. 11-524 and transmitted to both Houses of Congress for its review. D.C. Law 11-268 became effective on May 21, 1997.

Editor’s notes. — D.C. Law 11-268, § 10(s) (44 DCR 1730), eff. May 21, 1997, amends these sections subsequent to repeal.

